

00-06404

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

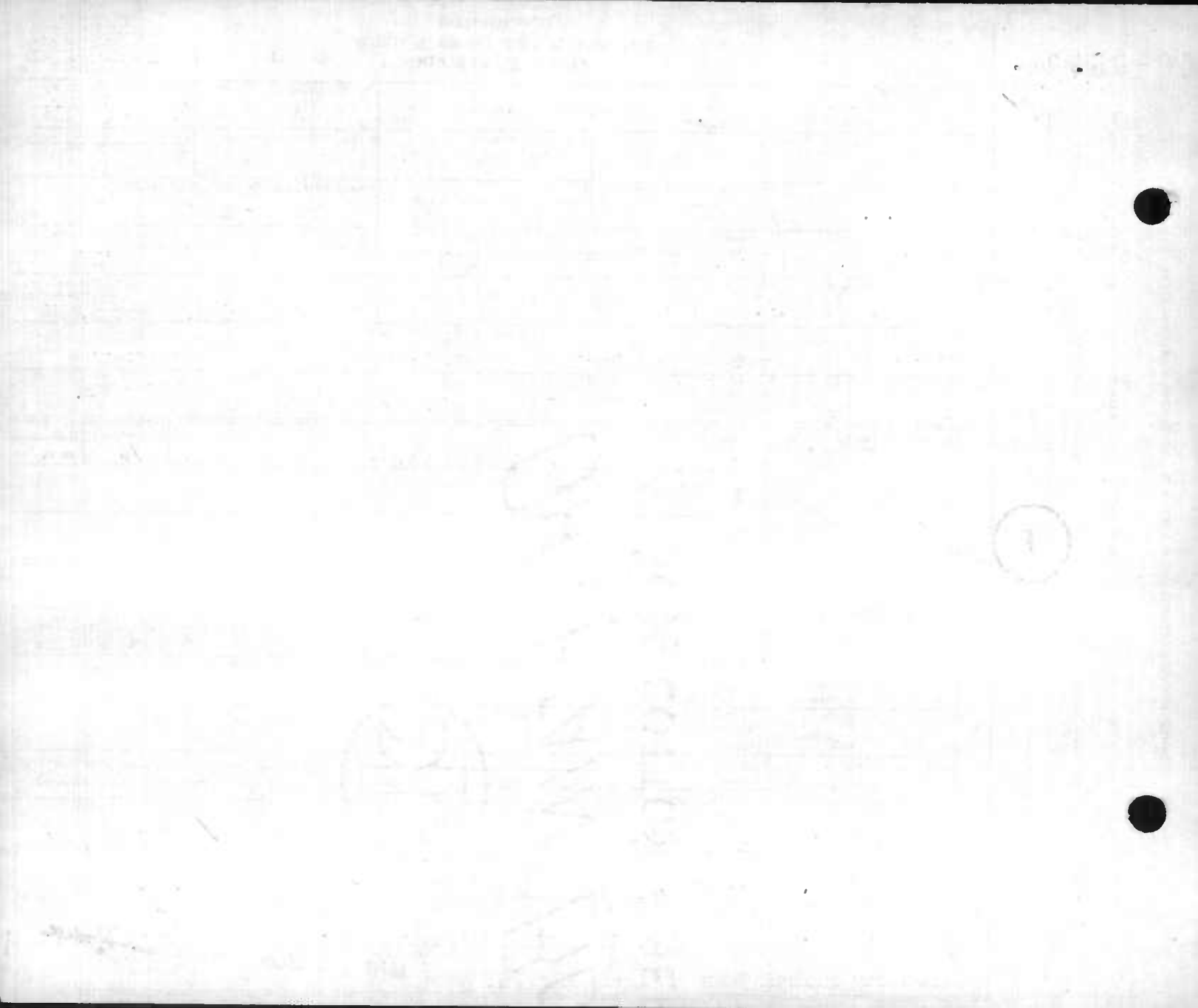
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place this certificate in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, only injury or traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		JACK C. ARCHAMBAULT				MAY 09 1986		0333 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS	
MALE		CAUCASIAN		AUG 06 1912		73			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
S.D.		USA				Anne Arundel MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT MEADE, MD		KIMBROUGH ARMY COMMUNITY HOSPITAL		USA RET		LTC			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		MD		A.A.		ODENTON		YES	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
Harry Joseph Archambault		Christine Canfield		Yes		WW II Korean 224 52 1517		488 Rita Dr. Odenton, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of lung		(b) DUE TO, OR AS A CONSEQUENCE OF		(c) DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		1yr 9 mos.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Francis X. Di Spaltro		Francis X. Di Spaltro		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		9 May 86.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. LOCATION CITY OR TOWN COUNTY STATE					
Francis X. Di Spaltro, CPT, MC		Kimbrough Army Community Hospital Ft Mead		Arlington Va					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		5-12-86		Arlington Nat. Cem.		Arlington Va			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REG. CLERK		25b. REGISTRATION SIGNATURE			
Hardesty Funeral Home		Annapolis, Md.		MAY 13 1986					



00-06574

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 3 1 4  
REG. NO. EDT

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BEATRICE VIRGINA AUSTIN			2a. DATE OF DEATH MONTH DAY YEAR MAY 13, 1986		2b. HOUR 815 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 4, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY A A Co	13c. CITY OR TOWN Severn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Chaney		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Mitchell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A 212.32.9745		17. INFORMANT (Daughter) ADDRESS Mrs. Doris V. Wesley Same as 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Charles J. W. M.D.</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/13/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. W. M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 204 GLEN BURNIE, MARYLAND 21061	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 16, 1986	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Md.
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Maryland	25a. DATE REC'D. BY REGISTRAR MAY 15 1986
		25b. REGISTRAR'S SIGNATURE <u>John A. ...</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 (how any injury, or other traumatic event, the medical examiner has the notified attending physician).

BP \_\_\_\_\_

PATIENT INFORMATION		CLINICAL INFORMATION		ADMINISTRATIVE INFORMATION	
NAME	DATE OF BIRTH	DATE OF ADMISSION	DATE OF DISCHARGE	ADMISSION NUMBER	DISCHARGE NUMBER
JOHN DOE	12/15/45	01/10/68	03/15/68	101	102
JANE DOE	08/22/48	02/01/68	04/10/68	103	104
JOHN DOE	03/10/50	01/20/68	03/20/68	105	106
JANE DOE	07/18/52	02/10/68	04/05/68	107	108
JOHN DOE	09/05/55	01/15/68	03/10/68	109	110
JANE DOE	11/01/58	02/05/68	04/01/68	111	112
JOHN DOE	04/12/60	01/25/68	03/25/68	113	114
JANE DOE	06/20/62	02/15/68	04/08/68	115	116
JOHN DOE	10/08/65	01/20/68	03/20/68	117	118
JANE DOE	12/10/68	02/10/68	04/05/68	119	120



MAY 15 1968



00-07483

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove captioned page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be called on for an autopsy.

FOR  
STATE  
REGISTRAR
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH
8 6 1 2 8 1 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph Harlan AUSTIN, Sr.			2a. DATE OF DEATH MONTH DAY YEAR May 14, 1986			2b. HOUR 5:00 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 2, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
12. CITY OR TOWN OF DEATH Crofton		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Center				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Freight Traffic Exp./Railroad		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland			16b. COUNTY Pr George's		16c. CITY OR TOWN Bowie		17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
18. FATHER'S NAME FIRST MIDDLE LAST Joseph William Austin			19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Mary Langhorne			20. STREET ADDRESS / ZIP CODE 3909 New Haven Court A-11 20716			
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			22. SOCIAL SECURITY NO. 718-10-6069		23. INFORMANT ADDRESS Edythe M. Austin same as 13c.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (the hospital) attended the deceased from <u>August 1</u> , 19 <u>85</u> , to <u>May 14</u> , 19 <u>86</u> , that (I) <u>lost</u> saw the deceased alive on <u>May 14</u> , 19 <u>86</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.									
22a. SIGNATURE <u>M. Karim</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 14, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Mobarak Karim, M. D.			22e. ADDRESS Suite 222 14300 Gallant Fox Lane Bowie, MD 20715						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE May 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Fairfax, Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Beall Funeral Home			ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043			25a. DATE REC'D. BY REGISTRAR MAY 23 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Peters</u>	

BP



00-06532

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return the original certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director is notified of this.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 1 6  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
FIRST MIDDLE LAST		MAY 7 1986		2140 M	
3. SEX		4. RACE		5. DATE OF BIRTH	
m		B		MONTH DAY YEAR	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Arnold		103 Green Valley Rd		Supervisor	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
md		A.A.		Arnold	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Eugene Agustus Baden		Laura Batters		yes	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
215-12-8119		Leola L. Baden		Arnold md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) adenocarcinoma prostate		IMMEDIATE CAUSE (a) adenocarcinoma prostate		2 yrs.	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
NA				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 1984, 19, to May 7, 1986, that (1) (we) last saw the deceased alive on 5/1/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
David S. McHown MD		ATTENDING PHYSICIAN		5/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
DAVID S. McHown		16 Murray Ave, ANNAP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5-12-86		Hill Crest	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
C. E. Hicks III		1922 Forest Drive		MAY 14 1986	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

SECTION 20



00-07383

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called along.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 2 3 1 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>marion K. Bainbridge</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5 17 86</i>			2b. HOUR <i>8<sup>25</sup> A.M.</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 15 34</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>52</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>England</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.			
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>413 Third St.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Electronics</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>413 Third St. 21403</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Kenneth Tompkus Bainbridge</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret Pitkin</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>554-46-8145</i>		17. INFORMANT ADDRESS <i>Muriel Jean Bainbridge #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Caecum</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>5-10</i> 19 <i>86</i> , to <i>5-17</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>5-10</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>S.P. Watkins</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>5/17/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S.P. Watkins</i>				22e. ADDRESS <i>Franklin St. Annapolis, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>5/17/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland P.O. Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Taylor Funeral Chapel Annapolis, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 22 1986</i>		25b. REGISTRAR'S SIGNATURE			

BP \_\_\_\_\_

00-01383

11/12



INDEX

MOBILE UNIT





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove certificate from page 2 and file it within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 1 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Justin Timmothy Barbour			2a. DATE OF DEATH MONTH DAY YEAR 5 3 86			2b. HOUR 6 40 p.m.			
3. SEX m		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 4 28 86		6. AGE (IN YEARS LAST BIRTHDAY) YRS. —		7. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —		12b. KIND OF BUSINESS OR INDUSTRY —	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				13a. STREET ADDRESS / ZIP CODE 1199 Hightown Dr. Annapolis			
13a. STATE N/A		13b. COUNTY N/A		13c. CITY OR TOWN N/A		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Brett Monroe Wallace				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Michelle Luisa Barbour					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS MICHELLE BARBOUR #13c					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANENCEPHALY DUE TO, OR AS A CONSEQUENCE OF (b) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/28/86, 19 86, to 5-3, 19 86, that (I) (we) lost saw the deceased alive on 5-3, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the medical examiner did not view the body after death, so state.)									
22b. SIGNATURE Kenneth Hoffman M.D.						22c. DATE SIGNED 5-3-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH HOFFMAN						22e. ADDRESS ANNE ARUNDEL GENERAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Cremation		23b. DATE MAY 6, 1986		23c. NAME OF CEMETERY OR CREMATORY Westview Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD			
24. FUNERAL DIRECTOR NAME T. A. Horvath						25a. DATE REC'D. BY REGISTRAR MAY 13 1986			
25b. REGISTRAR'S SIGNATURE John Davidson-Horvath									

1



1



15+1  
00007895

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 1 9  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elwood Barnett</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>May 26, 1986</b>		2b. HOUR M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 19, 1934</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A.Co.Md.</b> MD.		10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hosp.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Process Controller</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Soap-Manufc.</b>		13. STREET ADDRESS / ZIP CODE <b>21122</b> <b>8058 Solley Rd. Pasadena, Md.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Roscoe Barnett</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna - McMillian</b>		16. SOCIAL SECURITY NO. <b>216-30-6571</b>	
17. INFORMANT ADDRESS <b>Mrs. Joann Barnett, Same as above</b>		18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes,</b>		18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>9-55-9-57</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>	
--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>None</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>10/13 19 58 to 5/26 19 86</b>	
22a. I certify that (I) (the hospital) attended the deceased from <b>12/12 19 85</b> saw the deceased alive on <b>12/12 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.			
22b. SIGNATURE <b>R.M. McLaughlin, M.D.</b>		22c. DATE SIGNED <b>5/27/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. R.M. McLaughlin, M.D.</b>		22e. ADDRESS <b>3708 Monmouth Rd. Pasadena, Md.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-28-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem.Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, A.A.Co.Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Pasadena, Md. 21122</b> <b>McCully Funeral Home, Mt. &amp; Tickneck Rds.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 28 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson Randall</b>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon copies of pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-6-59

10-6-59



10-6-59

10-6-59

00007956

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

INSURGENT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 6		1 2 3 2 0		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
Mary Baxley				May 23 1986		3:15 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Aug. 14, 1917		68 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash. D.C.		U.S.A.				Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel General Hosp.		Supervisor		Telephone Co			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.		A.A. Co.		Edgewater		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		730 Londontown Rd. 21037	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
John T. Mulhall					Goldie Martha Greene				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no		no		577-01-1443 James Baxley same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for 10 lines; one line only)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Intentional flood -</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Respiratory failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Severe emphysema</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
<u>Generalized atherosclerosis - 5 FADIF</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 19 <u>86</u> to <u>5/23</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/22</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Joseph N. Friend</u>		M.D.				5/27/86			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
<u>Joseph N. Friend</u>		<u>205 Ridgely Ave. Annapolis, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		5-27-86		Lakemont		Davidsonville A.A. Md			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
T.A. Hardesty Annapolis Md. 21401				MAY 28 1986		<u>Davidson-Randall</u>			

153  
WATER  
XO

WATER  
XO





00-06572

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 2 8 2 1

1. DECEASED NAME (TYPE OR PRINT) <b>Jack S. Beasley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 14, 1986</b>			2b. HOUR MIN. <b>1:58 P M</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 23 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNAPOLIS</b> MD.				
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AA GEN Hospt.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto Agency</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto Ind.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4 Dock St. 21401</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>CARL BEASLEY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AURELIA STEVENS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1946-1952 269 14 0531</b>		17. INFORMANT ADDRESS <b>DONNA L. BEASLEY #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary heart disease</b>								15 years		
(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 24, 1970</b> to <b>May 14, 1986</b> , that (I) <del>was</del> last saw the deceased alive on <b>April 28, 1986</b> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>would</del> (did not) view the body after death.										
22b. SIGNATURE <b>Charles W. Kinzer</b>			DEGREE <b>CHARLES W. KINZER</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/14/86</b>		
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES W. KINZER</b>			23b. ADDRESS <b>MURRAY AVE ANNAPOLIS, MD.</b>							
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23d. DATE <b>5/15/86</b>		23e. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		23f. LOCATION <b>SUITLAND</b>		23g. REGISTRAR'S SIGNATURE <b>P.G. MD</b>	
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel</b>			ADDRESS <b>ANNAPOLIS, MD.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Curdson-Henderson</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the folder within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-08432

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 12822  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Sarah Berkowitz</b>		2a. DATE OF DEATH MONTH <b>MAY</b> DAY <b>31</b> YEAR <b>86</b>		2b. HOUR <b>8<sup>30</sup> P.M.</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>8</b> YEAR <b>90</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.	
10 CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MARYLAND</b> 13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4001 CLARKS LA. 21215</b>	
14 FATHER'S NAME FIRST <b>SAMUEL</b> MIDDLE <b>KLINE</b> LAST <b>KLINE</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ANNA</b> MIDDLE <b>CAPLAN</b> LAST <b>CAPLAN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO. <b>216-12-8536D</b>		17. INFORMANT <b>MRS. MIRIAM LANSBERG</b> APT. 108 <b>840 MONROE ST. ANNAPOLIS, MD 21403</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Arteriosclerotic Cardiovascular Disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/17</b> , 19 <b>86</b> , to <b>5/31</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>5/31</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert G. Goopnick</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/1/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert G. Goopnick</b>		22e. ADDRESS <b>95 Adelant Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JUNE 2, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>		23d. LOCATION <b>BALTIMORE</b> COUNTY <b>MARYLAND</b>	
24 FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME <b>6014 REISTERSTOWN RD. BALTO., MD 21215</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>JUN 4 1986</b>			
				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE  
LIBRARY



RECEIVED  
JAN 10 1900

100  
100

00-08119

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the funeral director. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or either is marked, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		86		12823		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DORCAS F. BILDERBACK</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>5 27 86</b>			2b. HOUR <b>5:20 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 / 16 / 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School Teacher</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>713 Warren Drive 21403</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George E. Fulton</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ramsey</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-36-1056</b>		17. INFORMANT ADDRESS <b>Willis P. Bilderback - Same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Septic shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Perirectal Abscess</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Shock lung, Glucose intolerance, severe metabolic acidosis, URINARY INFECTION</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/26</b> , 19 <b>86</b> , to <b>5/27</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/27</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Anthony J. Calabrese</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>5/27/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTHONY J. CALABRESE</b>				22e. ADDRESS <b>171 DEFENSE HWY ANNAP. MD 21401</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 30, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Anne's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD</b>			
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel - Annapolis, MD</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUN 2 1986</b>					

BP

Handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher but appears to contain several lines of prose.

3

Handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher but appears to contain several lines of prose.



00-08321

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 2 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Sarah E. Booze</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-31-86</b>		2b. HOUR <b>7:30 PM</b>
3. SEX <b>F</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9-3-05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <b>A.A. Co.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co., MD.</b>	
10. CITY OR TOWN OF DEATH <b>Ebenezer</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pleasant Living Conv. Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>SEVERNA PARK</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEVI HOLLAND</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>REBECCA STEWART</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-14-3252</b>		17. INFORMANT <b>846 Balto. Anna. Blvd.</b> <b>CATHERINE GALLOWAY Severna Pk., Md. 21146</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung Ca.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Charles W. Kinzer</b>		DEGREE <b>Charles W. Kinzer</b>		22c. DATE SIGNED <b>5-31-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles W. Kinzer</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-4-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER A.M.E. CEME.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Galesville A.A. Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>William Reese &amp; Sons Mortuary, P.A.</b>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>JUN 3 1986</b>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of injury.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the envelope and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_



0-07376

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6  
REG. NO.

1 2 8 2 5

1. DECEASED NAME (TYPE OR PRINT) <b>Gertrude Mary Borbonus</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 20, 1986</b>			2b. HOUR <b>7 a. M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-10-32</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD</b>				
10. CITY OR TOWN OF DEATH <b>Lothian</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>229 Atta Watch Way Lothian, Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? <b>NO</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John L. O'Day</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude M. Embert</b>			16. STREET ADDRESS <b>1206 Torrington Pl</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>Patricia A. Belschner 4267 Evergreen Rd. Pittsburgh, Pa. 15214</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Organ Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diffuse Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of the Breast</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3-10 86 5-4 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>650 Penn. Ave #35 Wash DC 20003</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>3-10 86</b> to <b>5-4 86</b> , that (I) (we) last saw the deceased alive on <b>5-4 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Elmer T. Carraro</b>					DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>5/20/86</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Elmer T. Carraro</b>					22e. ADDRESS <b>(675 4666) 650 Penn. Ave #35 Wash DC 20003</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>05-23-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton P.G. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Lee Funeral Home Inc. 6633 Old Alexander Ferry Rd. Clinton, Md. 20735</b>					DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE <b>MAY 22 1986 Julia Davidson-Randall</b>					

MEDICAL CERTIFICATION

25

35

160

2

2

9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the top of the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

9790-0

Nov 21, 1904

George's West Building



8021 S. 10th

00-07382

Item 2a, Film G617 7/17/86 jab STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 2 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BORDEN</b> <b>RICHARD L. BORDEN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>5 19 86</b>		2b. HOUR P M <b>P</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 21 24</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASH. DC.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b>	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>857 Bywater Rd</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel MD.</b>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>A.A.G.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DANIEL L. RAY BORDEN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PAULINE STONE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>EDITOR - WRITER</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>133 22 8739</b>		17. INFORMANT ADDRESS <b>CHRISTINA M. BORDEN #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>colonic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10 _____					
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/22 19 85</b> to <b>5/18 19 86</b> , that (I) (we) lost saw the deceased alive on <b>4/25 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stuart E. Selonick, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>5/19/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stuart E. Selonick, M.D.</b>		22e. ADDRESS <b>51 Franklin St. Annapolis, Md. 21205</b>			
23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>CREMATION</b>		23b. DATE <b>5/20/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LEONARD HILL CREM.</b>	
23d. LOCATION CITY OR TOWN COUNTY <b>SUITLAND P.G. MD.</b>		23e. DATE REC'D. BY REGISTRAR <b>MAY 22 1986</b>			
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral</b>		25a. REGISTRAR'S SIGNATURE <b>Gene Davidson</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please submit this certificate, pages 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-01361

Richard L. Borden

White 9 21 24

White

USA

Mass DC

822 Bynater Rd

Walden, N.H.

W.D.

Daniel LeRoy Borden

Payee

1822 822 Bynater Rd

Walden, N.H.



Richard L. Borden  
Walden, N.H.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

12827

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
JESSIE BELLE BOURKE		May 11, 1986		5:45 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female	White	August 26, 1893		92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland	USA			Anne Arundel MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Linthicum	106 Homewood Road	Principal		A A Co. Schools	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	A A Co.	Linthicum	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	106 Homewood Road 21090	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Jesse N. Suitt		Isabelle McCarter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Neice)	
No		217.14.5410D		Mrs. Susan S. Koon	
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Heart Failure</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Periphereal Vascular Insufficiency</u>		8 yr -			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u>		10 yr -			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> , 19 <u>76</u> , to <u>5/8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/8/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>G. S. Linsao</u>				5/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Dr. G. S. Linsao, M.D.		7308 Furnace Branch Rd, Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		May 14, 1986	Cedar Hill Cemetery		CITY OR TOWN COUNTY STATE
					Brooklyn A A Co. Md.
24. FUNERAL DIRECTOR		25a. DATE REG. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Singleton Funeral Home		MAY 13 1986		<u>[Signature]</u>	

RECEIVED 1988

NOV 14 1988



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		86		12828					
1. DECEASED NAME (TYPE OR PRINT) DOROTHY R. BOWEN				2a. DATE OF DEATH MONTH DAY YEAR 4/17/86		2b. HOUR 2200 M			
3. SEX F		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR 1-30-12		6. AGE (IN YEARS LAST BIRTHDAY) 74		7. UNDER 1 YEAR 8. UNDER 2-4 MRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co. MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 130 HEARNE PLACE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEC.		12b. KIND OF BUSINESS OR INDUSTRY Hosp.	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 130 HEARNE PL. 21403	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN RICHARDS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HILDA UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578145113		17. INFORMANT PAUL T. BOWEN JR		ADDRESS 722 PEGGY STREET DAVIDSONVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1982, 19, to 1986, 19, that (I) (we) lost saw the deceased alive on 5/17/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE SWATKINS				DEGREE ATTENDING PHYSICIAN				22c. DATE SIGNED 5/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SWATKINS				22e. ADDRESS RICHARD PEELE					
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 5-19-86		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE Westview Baltimore MD			
24. FUNERAL DIRECTOR NAME Robert S. Baranco		ADDRESS Sulima Rd.		DATE MAY 22 1986		REGISTRAR'S SIGNATURE John Davidson			

BP



0-09283

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 6 1 2 8 2 9	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Annie E. Broadt						2a. DATE OF DEATH MONTH DAY YEAR 5 28 86		2b. HOUR 5 P M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 12, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 90		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH EDGEWATER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 322 ARBUTUS DRIVE						12a. USUAL OCCUPATION (TYPE OF WORK, BUSINESS, OR WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND ANNE ARUNDEL EDGEWATER											
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS - ZIP CODE 322 ARBUTUS DR. 21037							
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT HENRY CANTLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERONICA C. SABOURY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-54-9939		17. INFORMANT ADDRESS SEVERNA A. TUCKER SAME AS 13E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <u>July</u> , 19 <u>85</u> , to <u>5/28</u> , 19 <u>86</u> , that (II) we lost above the deceased <u>5/21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) we (did) (did not) view the body after death.											
22b. SIGNATURE <u>Greg Neille</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>5/29/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GREG NEILLEY M.D.				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5-31-86		23c. NAME OF CEMETERY OR CREMATORY HILLCREST ANNAPOLIS		23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL CO. MD.			
24. FUNERAL DIRECTOR ROBERT E. EVANS ANNAPOLIS, MARYLAND						25a. DATE REC'D. BY REGISTRAR JUN 12 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

THE UNIVERSITY OF CHICAGO  
LIBRARY

*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph document, possibly a letter or a report, with some lines of text visible in the upper and lower portions.]*

*[Faint text lines visible in the upper portion of the page:]*

*[Faint text lines visible in the lower portion of the page:]*

00-06509

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2830

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF ESTI- DEATH MATED		MONTH		DAY		YEAR		26. HOUR							
Kay		Marie		Bromwell				<input checked="" type="checkbox"/> 5		10		1986				M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d HOUR			
F		W		6 4 46 39		39 YRS.		MONTHS		DAYS		HOURS		MIN		5		10		1986		1:40	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH																am	
NEW YORK		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Anne Arundel County																MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Anne Arundel		Anne Arundel General Hospital		SECRETARY		office																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
MD.		A.A.Co		EDGEWATER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1801 HAURE DE GRACE RD.															
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
ALFRED		HAZEL		No		126-34-8598		John KALINOSKI		EDGEWATER, MD.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Multiple injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
8150		Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF																	
(c)		DUE TO, OR AS A CONSEQUENCE OF																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:10 AM 5/10 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Driver of auto in collision with tree																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET Rt. 214&424, Davidsonville, AA Co., Maryland		CITY OR TOWN		COUNTY		STATE													
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		TITLE (SPECIFY) M.D. Chief		MEDICAL EXAMINER		DATE SIGNED May 11, 86															
ACTUAL SIGNATURE		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn Street, Balto., MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE													
CREMATION		5-12-86		West View		Catonsville		BALTIMORE		MD.													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Hardesty, F.H.		12. Ridgely Ave.		MAY 13 1986		John E. Smialek																	



Handwritten signature or text.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 3 1  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ruby Lee Burl</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>05-20-86</i>		2b. HOUR <i>12<sup>05</sup> AM</i>		
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>09-28-22</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YRS.	
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <i>N. Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>A.A. County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>N. Arundel Conv. Ctr.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Seamstress</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>A. A. Co</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Weaver Pittman</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ada Lee Laddie</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>			
17. SOCIAL SECURITY NO. <i>217-20-1882</i>		18. INFORMANT ADDRESS <i>Edward Russell Burl Same as #13</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *pancreas cancer with metastases*

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>Feb 20, 1986</i> to <i>May 20, 1986</i> , that (1) (we) last saw the deceased alive on <i>May 17, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>CHARLES J. WILSON</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>May 20, 1986</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHARLES J. WILSON</i>		22e. ADDRESS <i>7845 Oakwood Rd. Glen Burnie Md. 21061</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/22/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem Pk</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie A A Co. Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>McCully Funeral Homes 237 E. Patapsco Ave Balto., Md. 21225</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 23 1986</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return these certificates to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

10-07-52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 1 2 8 3 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Flora F Burr</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>5/13/1986</i>				2b. HOUR <i>6:50 a.m.</i>	
3. SEX <i>F</i>		4. RACE <i>C</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 4 99</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD					
10. CITY OR TOWN OF DEATH <i>Severna Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Meridian Nursing Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Packer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Blind Workshop for</i>			
13a. STATE <i>Md</i>				13b. COUNTY <i>AAC</i>		13c. CITY OR TOWN <i>Linthicum</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>20 Lake Front Drive, 21099</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>August Burr</i>				15. MOTHER'S MAIDEN NAME FIRST LAST <i>Marie Unknown</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>219-30-6423</i>		17. INFORMANT ADDRESS <i>Robert Schuman 20 Lake Front Dr Linthicum Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <i>5-13-</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (If not, did not view the body after death.)											
22b. SIGNATURE <i>Seenivasan</i> MD						22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED <i>5/14/86</i>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SEENIVASAN</i>						22f. ADDRESS <i>606 Hammond Lane, BALTO, Md, 21222</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>5/15/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY <i>Baltimore Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Hubbard Funeral Home, Inc.,</i>						24b. ADDRESS <i>4107 Wilkens Ave.</i>		25a. DATE <i>MAY 16 1986</i>			
						25b. BY REGISTRAR'S SIGNATURE <i>John A. ...</i>					

POST OFFICE

MAIL ROOM



MAY 16 1900

00-06072

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 3 4  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>SAMUEL James CARR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5/5/86</b>			2b. HOUR <b>11 50 AM</b>				
3. SEX <b>MALE</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 13 1901</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel MD</b>				
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Annapolis Convalescent Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Edgewater</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1070 Carrs Wharf Road 21037</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Robert Wilson Carr</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cox</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>212-18-8533</b>				17. INFORMANT <b>Francis Oliver Carr - Glen Burnie MD 21061</b>				18. ADDRESS <b>1681 Quarterfield Rd</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 887 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced age</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Fractured hip</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Myelomata 5/1/86</b>										
19a. DATE OF OPERATION <b>Feb 9 1983</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fractured hip</b>			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 9 1983</b> to <b>5/5 1986</b> , that (I) (we) last saw the deceased alive on <b>5/5 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the certifier did not view the body after death.)										
22b. SIGNATURE <b>Richard I. Hochman</b>						22c. DATE SIGNED <b>5/6/86</b>		22d. ADDRESS <b>16 Murray Avenue ANNAPOLIS MD 21401</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>May 9, 1986</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mayo Memorial</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mayo AA MD</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel - Annapolis, MD</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 9 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.



00-06773

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 3 3  
REG. NO.

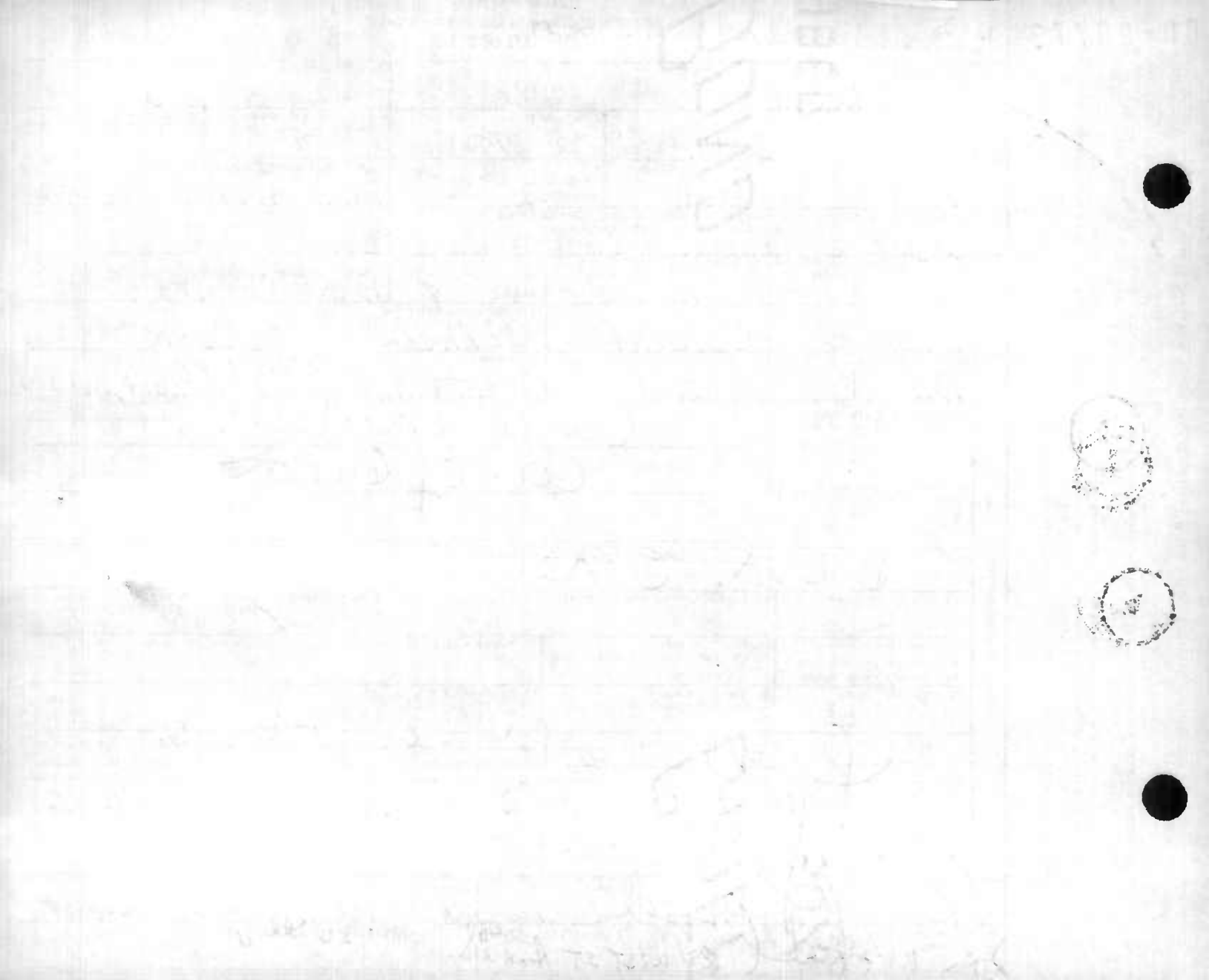
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCIE CARR			2a. DATE OF DEATH MONTH DAY YEAR 5 10 86		2b. HOUR M
3. SEX Female	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 2 15 14		6. AGE (IN YEARS LAST BIRTHDAY) 12 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH LEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ARUNDEL HEPATITIS NSC.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC WORK		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.	13b. COUNTY AN	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1300 Yorktown Rd 21401	
14. FATHER'S NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pierce Colbert	15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cornelia Cook		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 214-05-1262		17. INFORMANT 712 S. Hill Dr CHART Allan Carr ARISOLD MA 21012			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Ca. of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER (SIGNIFICANT) CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) OVAR @ ASCAD					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from April 5/14, 1986, to 5/10, 1986, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Elmo M. Gayoso		DEGREE MD		22c. DATE SIGNED 5/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/13-86		23c. NAME OF CEMETERY OR CREMATORY Asbury Heights	
23d. LOCATION (CITY OR TOWN) St. Margaret's		23e. COUNTY Anne Arundel			
24. FUNERAL DIRECTOR NAME Rogers & Sons Mortuary		ADDRESS 71401 821 WEST ST. ANN. MD.		25a. DATE RECEIVED BY REGISTRAR MAY 16 1986	
25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 25. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201





00-08274

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 3 5  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		Mary Jane Carter		May 28, 1986		10:55pm	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Sept. 21, 1893		92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Edgewater		Pleasant Living Convalescent Center		Post. Eng.		Civil Service	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE	
Maryland		A A Co.		Glen Burnie		419 Joyce Drive 21061	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
James Jubb		Mary Lawton		No		214.18.7684	
17. INFORMANT		17. ADDRESS		17. INFORMANT		17. ADDRESS	
Elton D. Carter (Son)		Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) Heat failure, chronic, progressive		IMMEDIATE CAUSE (a) Heat failure, chronic, progressive		IMMEDIATE CAUSE (a) Heat failure, chronic, progressive		IMMEDIATE CAUSE (a) Heat failure, chronic, progressive	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Pneumonia		Pneumonia		Pneumonia		Pneumonia	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:	
Renal failure		Renal failure		Renal failure		Renal failure	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 11, 1985 to May 28, 1986, that (I) (we) last saw the deceased alive on May 22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22a. I certify that (I) (this hospital) attended the deceased from March 11, 1985 to May 28, 1986, that (I) (we) last saw the deceased alive on May 22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22a. I certify that (I) (this hospital) attended the deceased from March 11, 1985 to May 28, 1986, that (I) (we) last saw the deceased alive on May 22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22a. I certify that (I) (this hospital) attended the deceased from March 11, 1985 to May 28, 1986, that (I) (we) last saw the deceased alive on May 22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.	
22b. SIGNATURE		22c. DEGREE		22d. DATE SIGNED			
Charles W. Kinn		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		5-29-86			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		June 2, 1986		Meadowridge Mem. Park		Elkridge Howard Md.	
24. FUNERAL DIRECTOR NAME ADDRESS		24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Sington Funeral Home		Glen Burnie, Maryland		JUN 3 1986		Julia Davidson-Henderson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

3

4



8-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

00-08273

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that each death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all nonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 3 6  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		1:45 P.M.	
FIRST MIDDLE LAST		May 31, 1986			
Mazie Matilda CAYER					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	# UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	77 YRS.	# UNDER 24 HRS.	
Jan 19, 1909					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Anne Arundel MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Glen Burnie	414 Maple Lane		Homemaker		Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		414 Maple Lane 21061	
Maryland Anne Arundel Glen Burnie					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Rubin McQuay		Fannie Morris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT (son) ADDRESS	
No None		218.42.1247		308 Argus Lane	
		George E. Cayer, Sr.		Glen Burnie, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Carcinoma of Breast + Lung</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
COPD					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-19-86</u> to <u>5-19-86</u> , that (I) (we) last saw the deceased alive on <u>5-19-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Marvin Feldman</u>		MD			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
MARVIN FELDMAN					
22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Jun. 3, 1986		Glen Haven Mem Park	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
AB J. [Signature]		JUN 3 1986		[Signature]	
Singleton Funeral Home, Glen Burnie, Md					

BP

8738

Continued from page 1

1950

1950

1950

1950

1950

1950

1950

00-06475

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 2 8 3 7

1. DECEASED NAME (TYPE OR PRINT) <b>FRANCIS M CHILTON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>5/1/86</b>				2b. HOUR <b>0017</b> M	
3. SEX <b>M</b>		4. RACE <b>C</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12/16/09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL CO. MD</b>			
10. CITY OR TOWN OF DEATH <b>DEALE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNA ARUNDAL GEN</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>WASH GAS + ELEC RETIRED.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>DEALE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>743 PARKERS CREEK R. 20751</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Chilton</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dempsey</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>577-014931</b>		17. INFORMANT <b>WIFE SAME AS ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>stroke</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 23</b> , 19 <b>84</b> , to <b>May 1</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Julie Buchanan</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>5-1-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Julie Buchanan</b>				22e. ADDRESS <b>4131 Shady Side Rd Shady Side MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/3/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Nat Cemetery Suitland PG Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 12 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julie Buchanan</b>			
4308 Suitland Road, Suitland, MD									

BP

1. The first part of the report  
describes the general situation  
of the country and the  
state of the economy.  
It also mentions the  
main problems which  
the government is facing.  
The second part of the  
report deals with the  
social and cultural  
aspects of the country.  
It mentions the  
main achievements  
of the government  
in this field.  
The third part of the  
report deals with the  
foreign relations of the  
country. It mentions  
the main achievements  
of the government  
in this field.

The fourth part of the  
report deals with the  
internal security of the  
country. It mentions  
the main achievements  
of the government  
in this field.  
The fifth part of the  
report deals with the  
international relations of  
the country. It mentions  
the main achievements  
of the government  
in this field.  
The sixth part of the  
report deals with the  
future of the country.  
It mentions the main  
achievements of the  
government in this  
field.

The seventh part of the  
report deals with the  
conclusion of the report.  
It mentions the main  
achievements of the  
government in this  
field.  
The eighth part of the  
report deals with the  
conclusion of the report.  
It mentions the main  
achievements of the  
government in this  
field.

00-05759

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 3 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Audrey Evelyn Ciccia			2a. DATE OF DEATH MONTH DAY YEAR May 1, 1986		2b. HOUR 5:45 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 30, 1937		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH A A Co. MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland			13b. COUNTY A A co.		13c. CITY OR TOWN Millersville	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 8251 Bernard Drive South 21108			
14. FATHER'S NAME FIRST MIDDLE LAST Millard Craft			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Bentley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT (Husband) Salvatore Ciccia		
16c. IF YES, GIVE WAR OR DATES None		16d. ADDRESS Same As 13				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Cardiac arrest.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) Liver cirrhosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 9, 1982</u> to <u>April 10, 1986</u> , that (I) (we) lost saw the deceased alive on <u>April 10, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/1/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ruben Reider, MD.				22e. ADDRESS 7445-A Furnance Branch Road, Glen Burnie, Md. 21061			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Baker Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Payne Gap Ky.	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home Glen Burnie, Maryland				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 6 1986			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

11

20X COIL 1100

WILKINSON



00-08390

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 3 9  
REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Aubrey M. Clifton			May 31, 1986			1854 <sup>M</sup>			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 13, 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 79		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A.Co. MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Davison Chemical	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN Maryland N.A.A. Baltimore			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 444 Carvel Beach Rd. (21226)				
14. FATHER'S NAME FIRST MIDDLE LAST Ernest S. Clifton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen M. Jones						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-07-7704		17. INFORMANT ADDRESS Mary F. Clifton (same as 13c)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probably Cardiac Dysrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fibrillatory Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) office		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-22</u> 19 <u>65</u> , to <u>Present</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/19</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Colvin C. Carter				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/2/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Colvin C. Carter M.D.				22e. ADDRESS 4710 Pennington Ave Balt., Md.					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE June 4, 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Ph., A.A.Co., Maryland			
24. FUNERAL DIRECTOR NAME George J. Gonce, 4001 Ritchie Hg., Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR JUN 4 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

1251

Handwritten text, possibly a title or description, located in the upper middle section of the page.

Handwritten text, possibly a list or detailed description, located in the lower middle section of the page.



00-07323

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 12840  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME <small>(TYPE OR PRINT)</small> To Ann Willex Coates		2a. DATE OF DEATH MONTH DAY YEAR May 21, 1986		2b. HOUR 8:15 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb 3 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a. BIRTHPLACE <small>(STATE OR FOREIGN)</small> OHIO	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small> 311 Macintosh Drive		12a. USUAL OCCUPATION <small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small> Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE <small>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)</small> MD		13b. COUNTY AA	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Willey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magdaline Ritter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(YES, NO OR UNKNOWN)</small> No	16b. SOCIAL SECURITY NO. <small>(IF YES, GIVE WAR OR DATES)</small> None	17. INFORMANT (Husband) Richard T. Coats		ADDRESS Same As 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED <small>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)</small>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY <small>(AT HOME STREET FACTORY OFFICE FARM ETC)</small>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 16, 1986, to May 21, 1986, that (I) (we) last saw the deceased alive on May 16, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard E. Shute		DEGREE M.D.		22c. DATE SIGNED May 21, 1986	
22d. PHYSICIAN'S NAME <small>(TYPE OR PRINT)</small> Howard F. Shute		22e. ADDRESS 205 Oak Ave, Severna Park, MD 21146			
23a. BURIAL, CREMATION, REMOVAL <small>(SPECIFY)</small> Burial	23b. DATE May 26, 1986	23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville AA Co. Md.	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR MAY 22 1986	25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove coffin in papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

LIBRARY OF CONGRESS

WALKER



00-07229

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 2 8 4 EDT

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LILLIAN</b>		MIDDLE <b>M.</b>		LAST <b>COMBS</b>		2a. DATE OF DEATH MONTH <b>MAY</b> DAY <b>19</b> YEAR <b>1986</b>		2b. HOUR <b>0640 AM</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>15</b> YEAR <b>08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home Maker</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>=====</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2208 Christian Street 21223</b>	
14. FATHER'S NAME FIRST <b>Ira</b> MIDDLE LAST <b>Miles</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Evelyn</b> MIDDLE LAST <b>=====</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-18-7445</b>		17. INFORMANT ADDRESS <b>Ira Gray Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsisemia, suspect</b> (b) <b>intro. abdomen. pathology</b> (c) <b>=====</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <b>① OVA</b> (b) <b>② dehydration</b> (c) <b>③ A.D.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5/18</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I (this hospital) attended the deceased from <b>5/18</b> 19 <b>86</b> to <b>5/19</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>5/19/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELMO M. GAYOSO, M.D.</b>		22e. ADDRESS <b>5411 OLD FREDERICK ROAD BALTIMORE, MARYLAND 21229</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>5/20/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto Md</b>			
24. FUNERAL DIRECTOR <b>George J. Gonca 4001 Ritchie Hwy Balto Md</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabs on page 1 and 2 and place them in the space provided on page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00000000

8

2011 OLD BERNHARD ROAD  
BALTIMORE, MARYLAND 21229

1320 N. GAVOON, N.D.


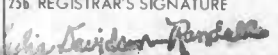
MAY 21 1961

00-08233

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. ~~IF~~ PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHW-17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 12842	
1. DECEASED NAME (TYPE OR PRINT) <b>GIAN -CARLO COPPOLLA</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>5 26 19 86</b>		2b. HOUR <b>6:30 P.M.</b>			
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 17, 1963 22 YRS.</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>22 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>5 26 19 86</b>		2d. HOUR <b>6:30 P.M.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK) <b>Film Maker-Motion Picture Indust</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>California</b>		13b. COUNTY <b>San Francisco</b>		13c. CITY OR TOWN <b>San Francisco</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>916 Kearney Street 99999</b>			
14. FATHER'S NAME <b>Francis Ford Coppola</b>				15. MOTHER'S MAIDEN NAME <b>Eleanor Neil</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>552 47 2951</b>		17. INFORMANT ADDRESS <b>Francis Ford Coppola same as #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cranio-cerebral trauma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <b>5:30 P.M.</b> MONTH DAY YEAR <b>5-26- 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Subject struck head while on boat that was in collision with tow line</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>water</b>		21f. LOCATION CITY OR TOWN <b>South River Edgewater, Anne Arundel MD</b>		21g. STATE <b>MD</b>					
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Assistant</b> M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>5-27-86</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St., Balto., MD 21201</b>									
23a. BURIAL, CREMATION, REMOVAL <b>Cremation</b>		23b. DATE <b>May 28, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION <b>Alexandria, Virginia</b> STATE					
24. FUNERAL DIRECTOR'S NAME <b>Dres-Pearson Funeral Homes Arlington, Va. 22201</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 2 1986</b>		25b. REGISTRAR'S SIGNATURE 					



00-000000

DAVID WHITEHEAD

225 COTTON STREET





0-05830

Items #1 5/13/86 mtb

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 8 4 3

1. DECEASED NAME (TYPE OR PRINT) <b>Clarence</b> <b>Alphonse</b> <b>Cox</b>		2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5-2-86</b>		2b. HOUR M <b>1710</b>
3. SEX <b>M</b>	4. RACE <b>CAU</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4-23-38</b>	6. AGE IN YEARS LAST BIRTHDAY YRS. <b>48</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Annapolis, Md.</b>		7b. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen.</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Realtor</b>
13a. STATE <b>Md</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Annapolis</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Cox</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Camilla Guy</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>
17. INFORMANT <b>Nancy C. Cox</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound, Chest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>5-2-86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self inflicted.</b>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Severn Grove Rd Annapolis Md</b>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>William P. Jones, M.D.</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>5/2/86</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>		ADDRESS <b>695 America Crt., Davidsonville, Md. 21035</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>	23b. DATE <b>5/6/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis, A.A.Co Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hardesty Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 6 1986</b>		
		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PMA-1000, PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

Letter to

Mr. J. H. ...

AA

Enclosed please find ...

AA ...

Enclosed please find ...

Very truly yours,

X

X

W. H. ...

10/10/02

SECTION 30% COTTON FIBERS

0-08575

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 4 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CARLOTA M. M. Cubillas</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>May 22, 1986</b>		2b. HOUR <b>9:30 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>Cuban</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 26, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cuba</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co., MD.</b>	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dietitian</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>
13a. STATE <b>Florida</b>	13b. COUNTY <b>Dade</b>	13c. CITY OR TOWN <b>North Miami</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1667 N.E. 142nd St 33181</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Antonio Cubillas</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Barroso</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>262-18-0627</b>		17. INFORMANT ADDRESS <b>Ann C. Cubillas (niece) Same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL / VENTRICULAR hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRAL VASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>POSSIBLE HYPERTENSION VASCULAR DISEASE</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1986</b> to <b>9:00am MAY 22, 86</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Thomas B. Ducker M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas B. Ducker M.D.</b>		22e. ADDRESS <b>100 CATHEDRAL ST ANNAPOLIS MD 21401</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>27 May 86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Park Cemetery, North</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Miami, Florida</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Capitol Funeral Service, Falls Church, VA</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1986</b> 25b. REGISTRAR'S SIGNATURE <b>John Darden</b>			



00-06056

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 2 8 4 5 EDT

1. FOR  
STATE  
REGISTRAR

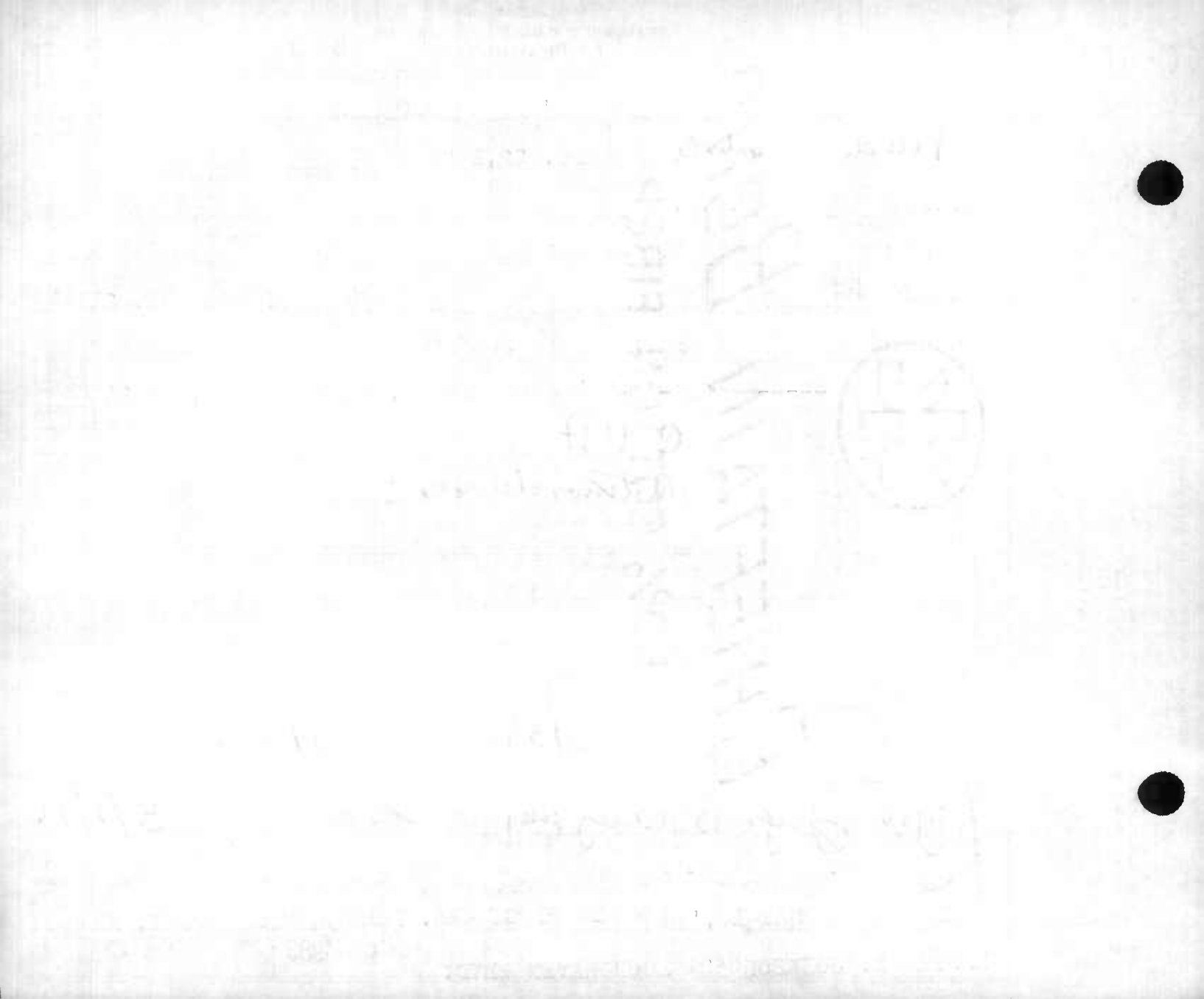
1. DECEASED NAME (TYPE OR PRINT) THERESA JOSEPHINE D'ALESSANDRO			2a. DATE OF DEATH MONTH DAY YEAR MAY 7, 1986			2b. HOUR 1:31 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 22, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY ARUNDEL		13c. CITY OR TOWN SEVERN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 654 DONALDSON AVE. 21144			
14. FATHER'S NAME FIRST MIDDLE LAST VINCENT PAPA			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CONCETTA BARRANCO						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-16-7840		17. INFORMANT ADDRESS JOSEPHINE M. WATTS SEVERN, MD 21144					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C U A DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE'S MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK WHILE <input type="checkbox"/> NOT AT WORK		21b. PLACE OF INJURY (HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 5/5/86 to 5/7/86, that (I) (we) last saw the deceased alive on 5/7/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22a. SIGNATURE Jorge B. Ramirez M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 5/7/86			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE B. RAMIREZ, M.D.				22d. ADDRESS 7845 OAKWOOD ROAD #205 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL BY BURIAL		23b. DATE MAY 10, '86		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE HOWARD COUNTY, MD			
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON				ADDRESS 8521 LOCH RAVEN BLVD.		25a. DATE REC'D. BY REGISTRAR MAY 9 1986		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



0000 - 06068

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 4 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EOLIN DOROTHY DAWSON</b>			2a. DATE OF DEATH MONTH <b>5</b> DAY <b>1</b> YEAR <b>86</b>			2b. HOUR <b>10:55 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>MAR</b> DAY <b>23</b> YEAR <b>1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MAYO MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL Co. MD.</b>	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNAPOLIS CONV. CTR.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>MARYLAND</b>				13b. CITY OR TOWN <b>AA Co ANNAPOLIS</b>		13c. STREET ADDRESS / ZIP CODE <b>1389 CAPE ST. CLAIRE RD 2140D</b>	
14. FATHER'S NAME FIRST <b>ROBERT</b> MIDDLE <b>WIT</b> LAST <b>WARD</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ALICE</b> MIDDLE <b>WARD</b> LAST <b>WARD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216 34 7247</b>		17. INFORMANT ADDRESS <b>Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Rip Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic Colon Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 mos.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>JAN 1</b> 19 <b>83</b> to <b>MAY 1</b> 19 <b>86</b> , that (1) (we) last saw the deceased alive on <b>APRIL 15</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>BARRY R. NATHANSON</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/1/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY R. NATHANSON</b>				22e. ADDRESS <b>51 FRANKLIN ST ANNAP.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/3/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MAYO MEM. CEM.</b>		23d. LOCATION OR TOWN <b>MAYO</b> COUNTY <b>AA Co MD</b>	
24. FUNERAL DIRECTOR NAME <b>TAYLOR FUNERAL CHAPEL</b> ADDRESS <b>ANNAPOLIS MD</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 9 1986</b>		25b. REGISTRAR'S SIGNATURE	

John Doe

of the State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York



00-07760

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 6 1 2 8 4 7		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) OTHA ELMON DAY					2a. DATE OF DEATH MONTH DAY YEAR MAY 22 86 10 28 AM			2b. HOUR	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 25, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMP		12b. KIND OF BUSINESS OR INDUSTRY GAS STATION	
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN SEVERN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 394 BURNS CROSSING RD. 21144	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN E. DAY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIRGINIA QUESENBURY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1920 to 23 220.16.9057		17. INFORMANT ADDRESS MARIAN V. DAY (WIFE) SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema / COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>6 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <u>5/16</u> 19 <u>86</u> , to <u>5/22</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) <u>examine the body after death.</u>									
22b. SIGNATURE <u>S. David Krims</u> DEGREE <u>M.D.</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>5/25/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S DAVID KRIMINS M.D.					22e. ADDRESS 25 SHAW STREET, ANNAPOLIS, MD 21401				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAY 27, 1986		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM PARK		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MD.		
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME, GLEN BURNIE, MD.						25a. DATE REC'D. BY REGISTRAR MAY 27 1986			
						25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Hendell</u>			

MEDICAL CERTIFICATION

00-01110

25474 NOTED 20



WILLIAM

1000

0-05756

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 8 4 8

1. DECEASED NAME (TYPE OR PRINT) <b>Edward William Dayhoff</b>			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>5-2-86</b>			2b. HOUR M <input type="checkbox"/> M <input type="checkbox"/> <b>2355</b>		
3. SEX <b>Male</b>	4. RACE <b>Can</b>	5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>6-25-20</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>65 YRS.</b>	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	IF UNDER 24 HRS. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>5-2-86</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA Anne Arundel, MD</b>		
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Police</b>	
13a. STATE <b>md</b>				13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>Dorsey</b> LAST <b>Dayhoff</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Irene</b> MIDDLE <b>Myra</b> LAST <b>Robinson</b>				15. ADDRESS <b>(21061)</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>W.W.II</b>		17. INFORMANT <b>Timothy E. Dayhoff / 1215 Cedar Cliff Dr.</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>A.I.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Diabetes Mellitus</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .	
ACTUAL SIGNATURE <b>William P. Jones</b>	TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>	DATE SIGNED <b>5/3/86</b>
ADDRESS <b>695 America Crt., Davidsonville, Md. 21035</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>May 7, 86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville State Vet.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville, Anne Arundel, Md.</b>
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Home</b> ADDRESS <b>3204 Mountain Rd. / Pasadena, Md. 21122</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 6 1986</b>	25b. REGISTRAR'S SIGNATURE <b>James Davidson-Randall</b>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

100-100

100-100

100-100

X

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

12  
00-07454

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 1 2 3 4 9 REG. NO. EDT			
1. FOR STATE REGISTRAR							
1 DECEASED NAME FIRST MIDDLE LAST MILDRED Bishop DePuey				2a. DATE OF DEATH MONTH DAY YEAR MAY 20, 1986			
3. SEX Female				4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 13, 1912	
6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.				7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7b. HOUR 015 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buyer, Retail-		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FLOYD HALE BISHOP		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JESSIE ALVERNA BIGGINS		13e. STREET ADDRESS / ZIP CODE 1900 Benesch Circle (21061)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-20-9692		17. INFORMANT ADDRESS Sandra A. Ervin/ 1251 Lorene Dr. (21122)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-18-1986</u> to <u>5-20-1986</u> , that (I) (we) last saw the deceased alive on <u>5-20-1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Evelyn Macain</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-21-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHACKIMKAL V. CYRAIC, M.D.		22e. ADDRESS 14 WELLMAN AVENUE, SUITE 101 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 23, 86		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.	
24. FUNERAL DIRECTOR NAME McCully Funeral Home/		24b. ADDRESS Pasadena, Md. 21122		25a. DATE REC'D. BY REGISTRAR MAY 23 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



00-08121

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Josephine J. Diefel</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5 28 86</b>			2b. HOUR <b>8:15 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 18 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>90</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.				
10. CITY OR TOWN OF DEATH <b>EDGEWATER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pleasant Living Conv. Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>115 Smith Avenue 21401</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alfred Michaelson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Samuels</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215-14-0041</b>	
17. INFORMANT <b>Jeannette Dart-Annapolis MD 21401</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease - Duration over 20 yrs.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus - (L) Cerebral Infarction</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES Mellitus - (L) Cerebral Infarction</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Charles W. Kinzer</b>			DEGREE			22c. DATE SIGNED <b>5/28/86</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles W. Kinzer, M.D.</b>			22e. ADDRESS <b>116 Murray Ave., Annapolis, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>May 31, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel - Annapolis, MD</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 2 1986</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION







00-06452

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6  
REG. NO.1 2 8 5 1  
EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANIHONY FRANCIS DOMINICK SR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 6, 1986</b>		2b. HOUR <b>1110 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasion</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 - 8 - 19</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>Maryland</b>		12b. CITY OR TOWN <b>Anne Arundel</b>		12c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		13a. STREET ADDRESS / ZIP CODE <b>623 Cypress Rd./21146</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>Elizabeth Dominick (Same as #13)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspirin poisoning</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Alzheimer's disease, diabetes mellitus.</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>5/1/86</b> to <b>5/6/86</b> , that (I) (we) last saw the deceased alive on <b>5/6/86</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Gerald Church</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>5/7/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GERALD CHURCH, M.D.</b>		22e. ADDRESS <b>8 EVERGREEN ROAD SEVERNA PARK, MARYLAND 21146</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5 - 9 - 86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery Glen Burnie A.A. MD.</b>		
24. FUNERAL DIRECTOR NAME <b>Barranco</b>		ADDRESS <b>495 Ritchie Hwy. Sev. Pk. MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 12 1986</b>		
		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Pendall</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

00-36752



Male

Caution

2 - 8 - 19

Pennsylvania United States

Police Bureau, Philadelphia

Arrested Anne Arnold Rev. Dr. 171-16-8483

Unknown

171-16-8483 (same as 171)

Serial

2 - 9 - 36 Glen Haven Cemetery Glen Morris A.A. No.

Barranco 405 Ritchie Hwy. Rev. Dr. 171-16-8483

0-08659

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12852

1. FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 22 86										26. HOUR M 1035	
1. DECEASED NAME FIRST MIDDLE LAST MARY LOUISE DUGANSKY										20. DATE KNOWN OF DEATH ESTI-MATED <input type="checkbox"/> MONTH DAY YEAR 5 22 86										26. HOUR M 1035	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 2-5-08		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		20. DATE PRONOUNCED DEAD 5 22 86		26. HOUR M 1035							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD									
10. CITY OR TOWN OF DEATH ANNAPOLIS				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 200 MCKENDREE AVE.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK TAX DEPT.				12b. KIND OF BUSINESS OR INDUSTRY STATE OF MARYLAND					
13a. STATE MARYLAND										13b. CITY OR TOWN ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 200 MCKENDREE AVE. 21401					
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES OWENS										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE B. CROSBY											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 219-30-4278				17. INFORMANT ADDRESS RAYMON A. DUGANSKY SAME AS 13E													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart attack - MI - acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10.																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <u>James E. Wheeler</u>				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER				DATE SIGNED 5-22-86									
EXAMINER'S NAME (TYPE OR PRINT) James E. Wheeler, M.D.				ADDRESS 1116 Gumbottom Rd. Crownsville 21032																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5-24-86				23c. NAME OF CEMETERY OR CREMATORY HILLCREST CEMETERY				23d. LOCATION CITY OR TOWN ANNAPOLIS A.A. CO. MARYLAND									
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS				ADDRESS ANNAPOLIS, MARYLAND				25a. DATE REC'D. BY REGISTRAR MAY 29 1986				25b. REGISTRAR'S SIGNATURE <u>Robert E. Evans</u>									

0-00000

NO. 100-100000



0-08113

Film G616 item 18-22a

FOR  
STATE 6/26/86 rja  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 8 5 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED MONTH DAY YEAR		2b. HOUR	
MARIE		E.		ELBEN				X		5 26 1986		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	June 9, 1914		71 YRS.						5 26 1986		2:47 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA		WIDOWED		DIVORCED		Anne Arundel County				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		Anne Arundel General Hosp.		Ret. Income Tax		State Gov't.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		AA		Annapolis		YES X NO		233 Farragut Road				21401	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
James Elmer Edelen		Rose Lee Wilkerson		NO		213-34-5958		Joyce Elben-		Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
				Multiple drug and alcohol intoxication									
				(b)		DUE TO, OR AS A CONSEQUENCE OF							
				(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES X NO							
				Abd. Only									
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		P.M. 5, 26 1986		Subject ingested drugs and alcohol									
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK X X X		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
				233 Farragut Rd.		Annapolis		Anne Arundel		Md.			
22a. I certify that I took charge of the remains described above, held an		Autopsy X		Inspection		Inquiry		and in my opinion					
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
ACTUAL SIGNATURE		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		5-27-86					
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.		ADDRESS		111 Penn St., Balto., MD		21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		May 29, 1986		Hillcrest		Annapolis		AA		MD			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Taylor Funeral Chapel-Annapolis, MD				JUN 2 1986									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, AND FORWARD IT TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MBP/168  
DHMH - 17  
(VR A15 ME (5))



00-07107

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 5 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST ALMA MIDDLE B. LAST FAGUE <i>Alma B. Fague</i>			2a. DATE OF DEATH MONTH 5 DAY 16 YEAR 86 HOUR 601 AM		
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH 6 DAY 13 YEAR 04 <i>6/13/04</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>		6. AGE (IN YEARS LAST BIRTHDAY) 81 81 YRS. MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH <i>Brooklyn</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hammond Lane Meridan</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County MD.</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Clerk -</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Federal Gov't.</i>		
13a. STATE <i>Maryland</i>			13b. CITY OR TOWN <i>Catonsville</i>		13c. STREET ADDRESS / ZIP CODE <i>10 Oella Avenue 21228</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Josiah T. Beckman</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hester Lipcomb</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>579-22-1468</i>		17. INFORMANT ADDRESS <i>Mary Simpson 12 Saratoga Drive New Castle, Delaware 19720</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>MULTIPLE Cerebro-Vascular Accidents.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>HYPERTENSIVE ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 year 10 year</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELEVANT TO THE IMMEDIATE CAUSE OF DEATH <i>DIABETES MELLITUS.</i>					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>7/27/81</i> , to <i>5/16/86</i> , that (I) (we) last saw the deceased alive on <i>5/15/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Harjit Singh</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>5/16/86.</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HARJIT SINGH M.D.</i>		22e. ADDRESS <i>#8, 16th AVE. BALTIMORE, Md. 21225.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/19/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie Maryland</i>		23e. DATE REC'D. BY REGISTRAR <i>MAY 20 1986</i>			
24. FUNERAL DIRECTOR NAME <i>Letitia M. &amp; Russell C. Witzke Funeral Homes P.A.</i>		ADDRESS <i>1630 Edmondson Avenue, Catonsville, MD. 21228</i>		23f. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>	





*[Faint, mostly illegible text in the upper and middle sections of the page, possibly bleed-through from the reverse side.]*

*[Faint, mostly illegible text in the lower section of the page, possibly bleed-through from the reverse side.]*



00-06770

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8612855 REG. NO. EDT	
1. DECEASED NAME (TYPE OR PRINT) AKA <b>Magdalena</b> MIDDLE <b>R. Farnés</b> LAST <b>MARIA MAGDALENA FARNÉS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 14, 1986</b>			2b. HOUR <b>9:50</b> A M			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 10, 1911</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Puerto Rico</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.					
10 CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saleswoman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Singer Sewing Machine</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6208 Harris Hgts Ave. 21061</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Emilio Rodriguez</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carmen Rodriguez</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>058 14 3125</b>		17 INFORMANT ADDRESS <b>Frank Sopato same as 13 e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>May 13, 1986</u> to <u>May 14, 1986</u> , that (I) (we) last saw the deceased alive on <u>May 14, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE				22c. DATE SIGNED <u>May 14, 86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES J. WU, M.D.</b>				22e. ADDRESS <b>7845 OAKWOOD ROAD #204 GLEN BURNIE, MARYLAND 21061</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/17/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Balto. Md. 21225 George J. Gonce 4001 Ritchie Hgwy.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1986</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/10/01 BY SP-6 [illegible]

U.S. DEPARTMENT OF JUSTICE

MEMORANDUM

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]



0-05961

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

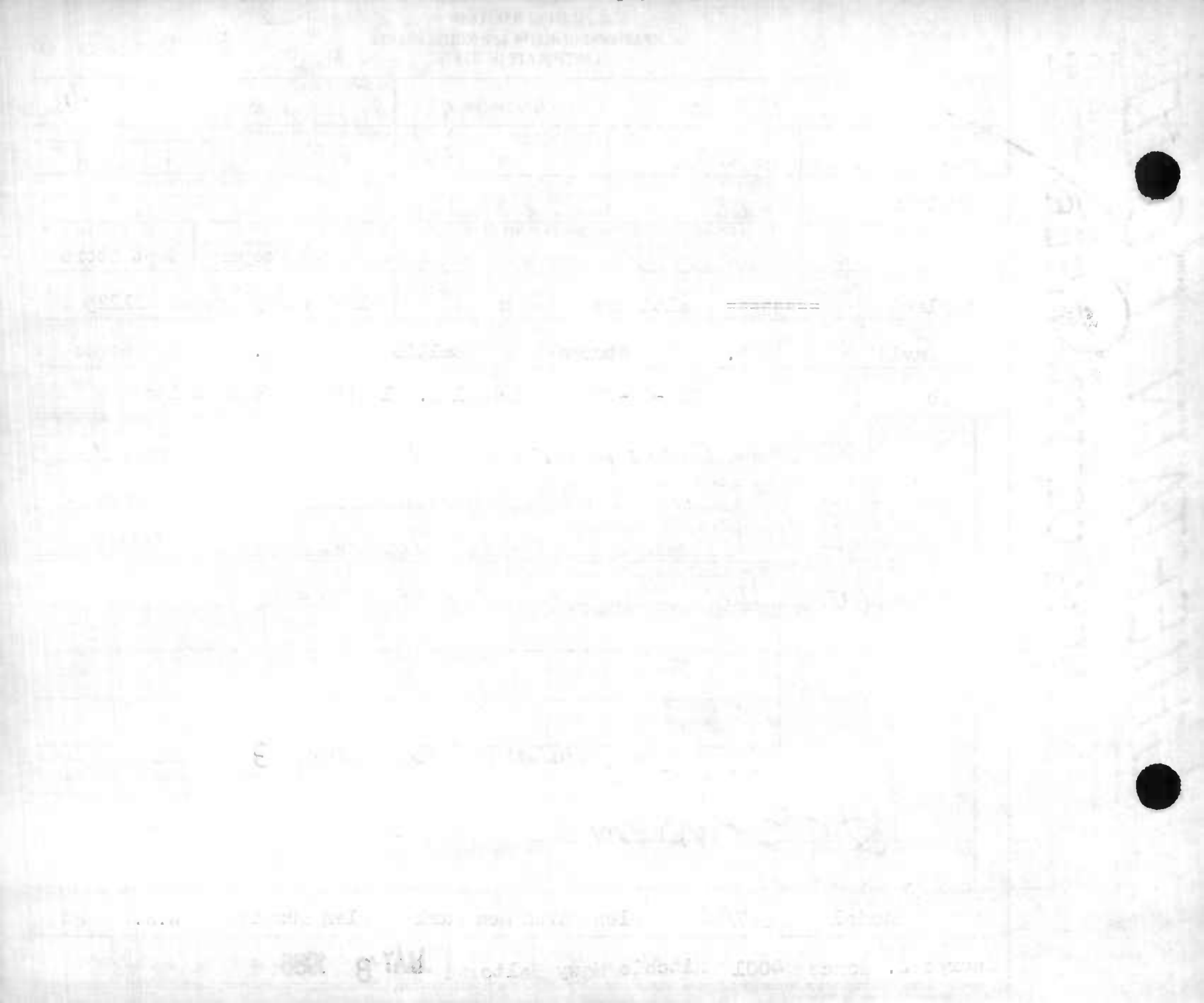
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 2 8 5 6 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Sara L B Fleming</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-3-86</b>			2b. HOUR <b>8<sup>25</sup> PM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 3 24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.					
13. CITY OR TOWN OF DEATH <b>Millersville</b>			14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Knollwood Manor Nursing Home</b>			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Book Keeper</b>			16. KIND OF BUSINESS OR INDUSTRY <b>Dept Store</b>		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE <b>Maryland</b> 17b. COUNTY <b>V</b> 17c. CITY OR TOWN <b>Baltimore</b>			18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			19. STREET ADDRESS / ZIP CODE <b>4124 Audrey Avenue 21225</b>					
20. FATHER'S NAME FIRST MIDDLE LAST <b>David W. Osborne</b>			21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Callie E. Neeves</b>								
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			23. SOCIAL SECURITY NO. <b>215-26-7764</b>			24. INFORMANT <b>Michael A. Fleming</b>			25. ADDRESS <b>Same as 13c</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>coronary artery disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b> <b>Immed.</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>metastatic lung carcinoma, hepatic metastases</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 19 83</b> to <b>MAY 3, 19 86</b> , that (I) (we) last saw the deceased alive on <b>April 24, 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Dr. Ira Kaplan</b>						DEGREE			22c. DATE SIGNED <b>5/7/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Ira Kaplan</b>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/7/86</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>George J. Gonce 4001 Ritchie Hgwy Balto Md</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1986</b>			25b. REGISTRAR'S SIGNATURE <b>John Switzer</b>		



00-08690

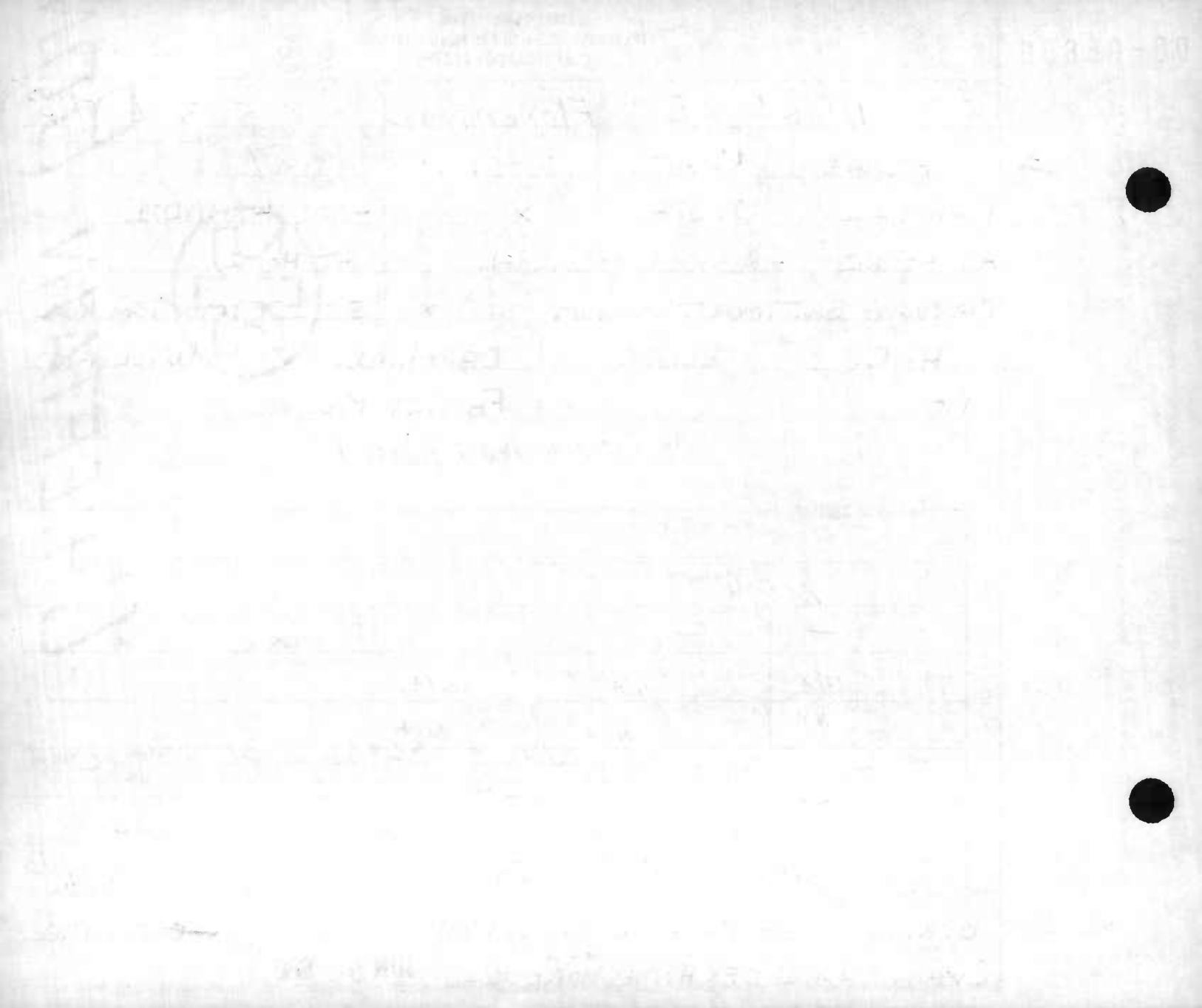
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "N/A", item 18 should be marked as "N/A".

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8612857 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary E Florentine						2a. DATE OF DEATH MONTH DAY YEAR 5-31-86			2b. HOUR 7:05 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-21-1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anns Arundel MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ARUNDel General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT Home			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland						13b. COUNTY BARTIMORETIMONIUM		13c. CITY OR TOWN 21093		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST H. C. ELDER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE V. Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS FAMILY RECORDS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a											
none											
19a. DATE OF OPERATION -				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) N/A					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK N/A				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A					
22a. I certify that (1) this hospital attended the deceased from 5/26, 1986, to 5-31, 1986, the (1) (we) lost above, (1) (we) (did) not view the body after death.											
22b. SIGNATURE Thomas Walsh						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-4-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS WALSH MD						22e. ADDRESS 780 Ritchie Highway Severna Park Md 21146					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-5-86		23c. NAME OF CEMETERY OR CREMATORY DULANSY VALLEY		23d. LOCATION CITY OR TOWN COUNTY STATE TIMONIUM BALTO. MO.			
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF CHIMES YORK ROAD						25a. DATE REC'D. BY REGISTRAR JUN 5 1986		25b. REGISTRAR'S SIGNATURE John Landon			



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0-0831

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8612858	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GEMMA L. FORMAN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>5 27 86</b>			2b. HOUR <b>10:30<sup>P</sup></b>		
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 12 25</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>459 NOLHEIGHT ROAD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETERY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>459 Nolheight Road 21061</b>			
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>ALFREDO FESTA</b>				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>127 18 2085</b>		16c. PLACE OF BIRTH <b>Fort Carson, Colorado 80913</b> <b>David A. Forman 7230 "B" Quarters</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer of breast - lung &amp; bones, advanced</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION <b>Oct. 1981</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Breast cancer</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct.</b> 19 <b>81</b> , to <b>May</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5-18-86</b> 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>A. Shamim MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>5-28-86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AHMAD SHAMIM</b>				22e. ADDRESS <b>Laurel, Maryland Suite 9 Steward Towers 200 Fort Meade Road</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/31/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Baptist Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rome Oneida New York</b>		25a. DATE RECEIVED BY REGISTRAR <b>MAY 28 1986</b>			
24. FUNERAL DIRECTOR NAME <b>Raymond C. Fink Glen Burnie, Md. 21061</b>						25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodette</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

14-70-2

Page 1 of 1

1. The first part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

2. The second part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: Alice Brown, Charlie White, and David Green. The addresses are: 101 Pine St, 202 Cedar St, and 303 Birch St.

3. The third part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: Eve Black, Frank Gray, and Grace Blue. The addresses are: 404 Spruce St, 505 Fir St, and 606 Willow St.

4. The fourth part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: Henry Red, Irene Yellow, and Jack Purple. The addresses are: 707 Ash St, 808 Hickory St, and 909 Sycamore St.

5. The fifth part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: Karen Orange, Larry Pink, and Mary Silver. The addresses are: 1010 Magnolia St, 1111 Dogwood St, and 1212 Redwood St.

6. The sixth part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: Norman Gold, Olivia Bronze, and Paul Copper. The addresses are: 1313 Cypress St, 1414 Juniper St, and 1515 Cottonwood St.

7. The seventh part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: Quinn Iron, Ryan Steel, and Sarah Tin. The addresses are: 1616 Walnut St, 1717 Chestnut St, and 1818 Pecan St.

8. The eighth part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: Tom Lead, Ursula Zinc, and Victor Nickel. The addresses are: 1919 Maple St, 2020 Poplar St, and 2121 Cherry St.



00-06504

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from this form. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, view any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 5 9  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Catherine (NMI) Fox			2a. DATE OF DEATH MONTH DAY YEAR May 9, 1986		2b. HOUR 7:15 P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Crofton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Crofton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE 1711 Fillmore Court 21114			14. FATHER'S NAME FIRST MIDDLE LAST Michael McHugh		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Flaherty			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		
16b. SOCIAL SECURITY NO. 144-03-6410D			17. INFORMANT ADDRESS Dorothy F. Otterbacher same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA - PROBABLE DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE URINARY TRACT INFECTION. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 d. 5-6 d.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: S/P PREVIOUS STROKE. PACE MAKER INSERTION. DIFFUSE ARTHRITIS.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 19 85, to MAY 9 19 86, that (I) (we) lost saw the deceased alive on MAY 9 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Frank R. Jackson, MD		DEGREE MD		22c. DATE SIGNED 5-9-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK JACKSON		22e. ADDRESS 3 VILLAGE GREEN, CROFTON MD 21114			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Transit-burial		23b. DATE May 13 1986	23c. NAME OF CEMETERY OR CREMATORY Princeton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Princeton, New Jersey
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Rd. Bowie, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 14 1986	



0-08320

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 6 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth O GRAY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-28-86</b>			2b. HOUR <b>8:40 PM</b>				
3. SEX <b>F.</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 23 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1 College Creek Terrace 21401</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LOUIS JENNINGS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH GREEN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-16-8083</b>		17. INFORMANT <b>Annapolis, Md. 21403</b> <b>JOANN PARKER 1393 Tyler Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Intracranial Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterial Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 HRS</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5/28 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <b>5/28 1986</b> to <b>5/28 1986</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>5/28 1986</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.										
22b. SIGNATURE <b>Peter F. Verkouw</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/28/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER F. VERKOUW MD</b>			22e. ADDRESS <b>1833 Forest Dr. Annapolis, Md 21401</b>							
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			23b. DATE <b>6-2-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINELAWN MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Maryland</b>			
24. FUNERAL DIRECTOR <b>Annapolis, Md. 21401</b> NAME ADDRESS <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 3 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Jana Davidson</b>			

MEDICAL CERTIFICATION

0-05350

UNITED STATES OF AMERICA

1946

1946



UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA



UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

Items 15 &amp; 17 per ph. call F.H.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

1 2 3 6 1

00-05798

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
*Walter Wm Greenleaf*

2a. DATE OF DEATH MONTH DAY YEAR  
*5 - 3 - 86*

7b. HOUR  
*9:35* M

3. SEX  
*Male*

4. RACE  
*Black*

5. DATE OF BIRTH MONTH DAY YEAR  
*1 23 61*

6. AGE (IN YEARS LAST BIRTHDAY)  
*85* YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
*Maryland*

7b. CITIZEN OF WHAT COUNTRY?  
*US*

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
*Anne Arundel County* MD.

10. CITY OR TOWN OF DEATH  
*Bullisville*

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
*Shallwood Manor Nursing Home*

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
*Labourer*

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN  
*Maryland* *AA* *Lanham*

13b. INSIDE CITY LIMITS? YES ☐ NO ☒

13c. STREET ADDRESS / ZIP CODE  
*1190 Martha Greenleaf Dr.*

14. FATHER'S NAME FIRST MIDDLE LAST  
*Henry Greenleaf*

15. MOTHER'S MAIDEN NAME  
*Martha Thomas*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
*NO*

16b. SOCIAL SECURITY NO.  
*110*

17. INFORMANT ADDRESS  
*Margaret Queen* *Shantilly, Md.* *1190 Martha Greenleaf Dr.*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) *Congestive Heart failure*  
DUE TO, OR AS A CONSEQUENCE OF (b) *Renal failure*  
DUE TO, OR AS A CONSEQUENCE OF (c) *Pneumonia*  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *110*

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
*P.M. 19*

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from *5-3-86* 19 *86*, to *5-3-86* 19 *86*, that *I* (we) last saw the deceased alive on *5-3-86* 19 *86*, and that in *(my)* (our) opinion death occurred on the date and hour and from the causes stated above. *(I)* (we) (did) (did not) view the body after death.

22b. SIGNATURE  
*[Signature]* DEGREE

22c. DATE SIGNED  
*5/4/86*

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
*Dr. D. Sawhney*

22e. ADDRESS  
*7422 Balto. & Annapolis Blvd. Lanham, Md.*

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
*Burial*

23b. DATE  
*5/8/86*

23c. NAME OF CEMETERY OR CREMATORY  
*Wilson Memorial*

23d. LOCATION CITY OR TOWN COUNTY STATE  
*Lanham AA Md*

24. FUNERAL DIRECTOR NAME ADDRESS  
*Wm Reese & Sons - Annapolis, Md*

25a. DATE REC'D. BY REGISTRAR  
*MAY 6 1986*

25b. REGISTRAR'S SIGNATURE  
*Julia Davidson*

100

00-05763

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 6 2  
REG. NO. EDT

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST JESSE SLOAN GRICE		2a. DATE OF DEATH MONTH DAY YEAR MAY 3, 1986		2b. HOUR 3:20 A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 23, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accounting		12b. KIND OF BUSINESS OR INDUSTRY Book keeping	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1208 Kenwood Road 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Raeferd Grice		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Sloan		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT ADDRESS Harriet B. Grice Wife Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic cardiovascular disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>congestive heart failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>85</u> , to <u>5/3</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>5/3/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES J. BENJAMIN, M.D.				22e. ADDRESS 653 OLD MILL ROAD MILLERSVILLE, MARYLAND 21108					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Md.				25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 showing injury, or other traumatic event, the medical examiner must be notified.

BP

FOR COLLECTION, LIBRARY

WILSON DOWD.



00-000000



0507247

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12863

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JULIE BAXLEY GUNTER</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5-18-86 19			2b. HOUR M		
3. SEX <b>Female</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 16 1919</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD <b>5-18-86 19</b>	7d. HOUR <b>2:20 PM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Pasadena</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William P Baxley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220 14 6875</b>		17. INFORMANT ADDRESS <b>Linda Allman 811 224th st 21122</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1258 AM 5-18-86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self/inflicted</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7835 E. Shore Rd/ Pasadena, Maryland</b>				
22a. I certify that I took charge of the remains described above and that the death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> (HEAD ONLY Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) <b>M.D. Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>5-19-86</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>5 23 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville (B.) Md</b>		
24. FUNERAL DIRECTOR NAME <b>Raymond C Fink</b>				ADDRESS <b>Glen Burnie, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1986</b>		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson</i>



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 6 4  
REG NO.

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
HUGH		G.		HAMILL		5		30 86	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR 11 5 97		88 YRS.		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Anne Arundel			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Crownsville		711 Whitney Landing Drive		Retired		Laborer			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Anne Arundel		Crownsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		711 Whitney Landing Drive 21032	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Hugh F. Hamill		Wilhelmina Tidemann							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		20877	
No		215 05 4776		John Hamill		78 West Deer Park		Gaithersburg	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		Dysrhythmia				minutes			
				(b) Aortic Stenosis		Years			
				(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		Congestive Heart Failure, Chronic Renal Insufficiency							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JAN 17 19 86 to MAY 30 19 86, that (I) (we) lost saw the deceased alive on MAY 23 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Robert N Koshler		MD				5/30/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
ROBERT N KOSHLER		780 Ritchie Highway		Savanna Park MD 21146					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		June 2, 1986		Westview Memorial Pk		Catonsville Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Harry H Witzke & Family Funeral Home Inc. 4112 Old Columbia Pike Ellicott City		JUN 2 1986		Julia Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

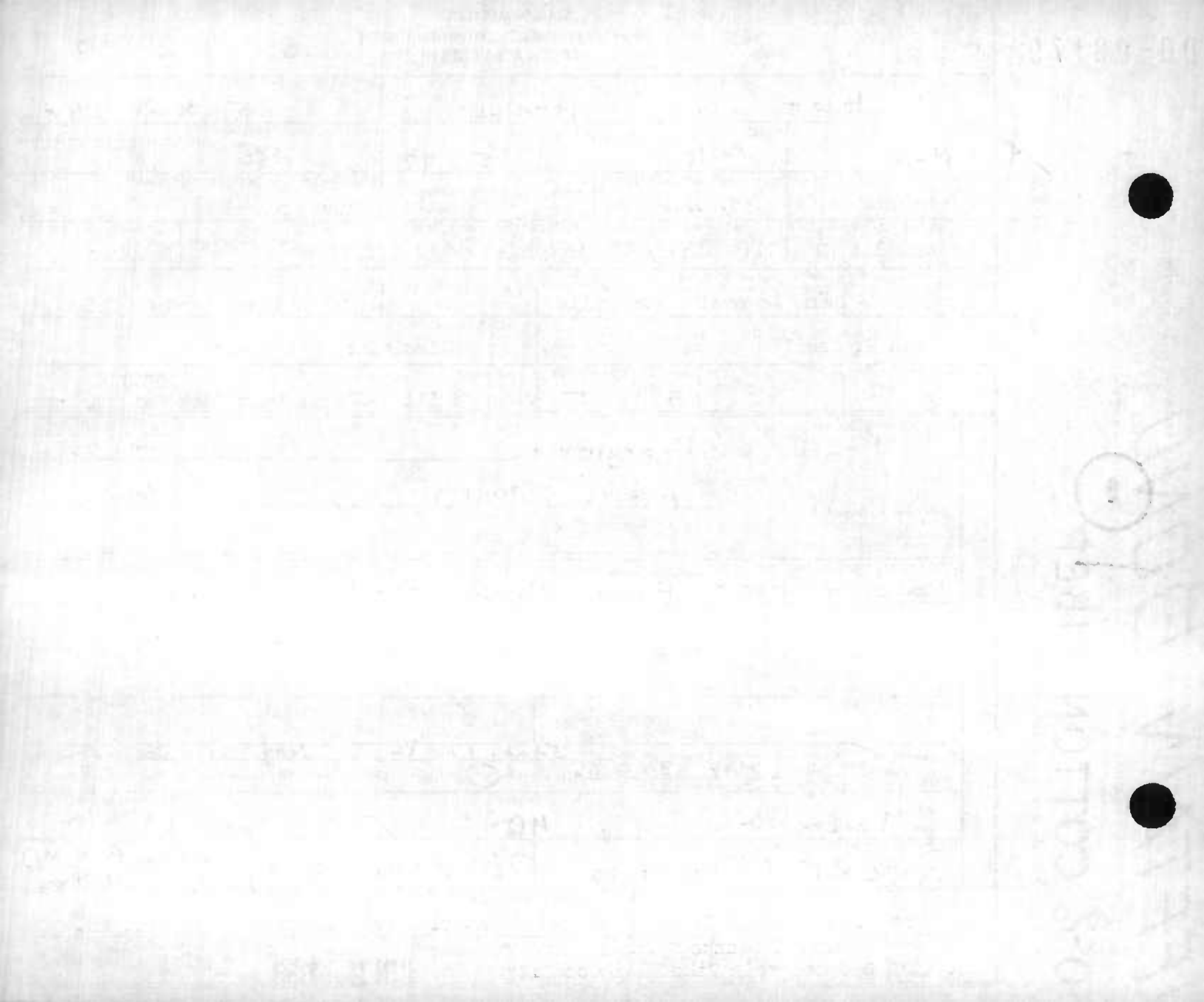
NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP \_\_\_\_\_



00-07197

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 12865  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Harris			2a. DATE OF DEATH MONTH DAY YEAR 5-18-86			2b. HOUR 45 M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7-13-1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN HARRIS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY SIMON			13e. STREET ADDRESS / ZIP CODE 815 B Betsy Court 21401			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-07-3325		17. INFORMANT Annapolis, Md. 21401 MARY EDWARDS 815 B Betsy Court					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: (b) CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF: (c) ANTERIOGRADIC VASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 83 to 5/18 19 86, that (we) last saw the deceased alive on 5/18 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald C. Reese, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 5/19/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald C. Reese, M.D.						22e. ADDRESS 1616 Forest St Annapolis 21403			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5-22-1986		23c. NAME OF CEMETERY OR CREMATORY FOWLERS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. 21401						25a. DATE REC'D. BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the non-ops. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified orally.



00-07209

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical certificate must be signed and stamped.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR <b>Alice E. Hartless</b>					8 6 1 2 3 6 6 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Alice Elizabeth Hartless</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>5 17 86</b>			2b. HOUR <b>3:15 P.M.</b>		
1. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 19 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD				
10. CITY OR TOWN OF DEATH <b>Brooklyn Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5228 Fourth Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Brockton K</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5228 Fourth Street 21225</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILEY M. LIPSCOMB</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY G.</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>225-14-6833</b>		17. INFORMANT ADDRESS <b>HENRY HARTLESS (SAME AS 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Astrocystoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9 May</b> 19 <b>86</b> , to <b>17 May</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>16 May</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Howard E. Shute</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>5/17/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Howard E. Shute M.D.</b>					22e. ADDRESS <b>205 Oak Avenue, Severna Park MD 21146</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/21/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn Mem Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>George J. Gonce 4001 Ritchie Hwy.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>			

MEDICAL CERTIFICATION

10-01200

Alice B. Harless

RECEIVED MAY 10 1900

MAILED MAY 10 1900



George L. Gorce 4001 Little Hwy.  
Baltimore, Md.  
May 10 1900  
Baltimore, Maryland



00-05758

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

861286 EDT  
REG. NO.

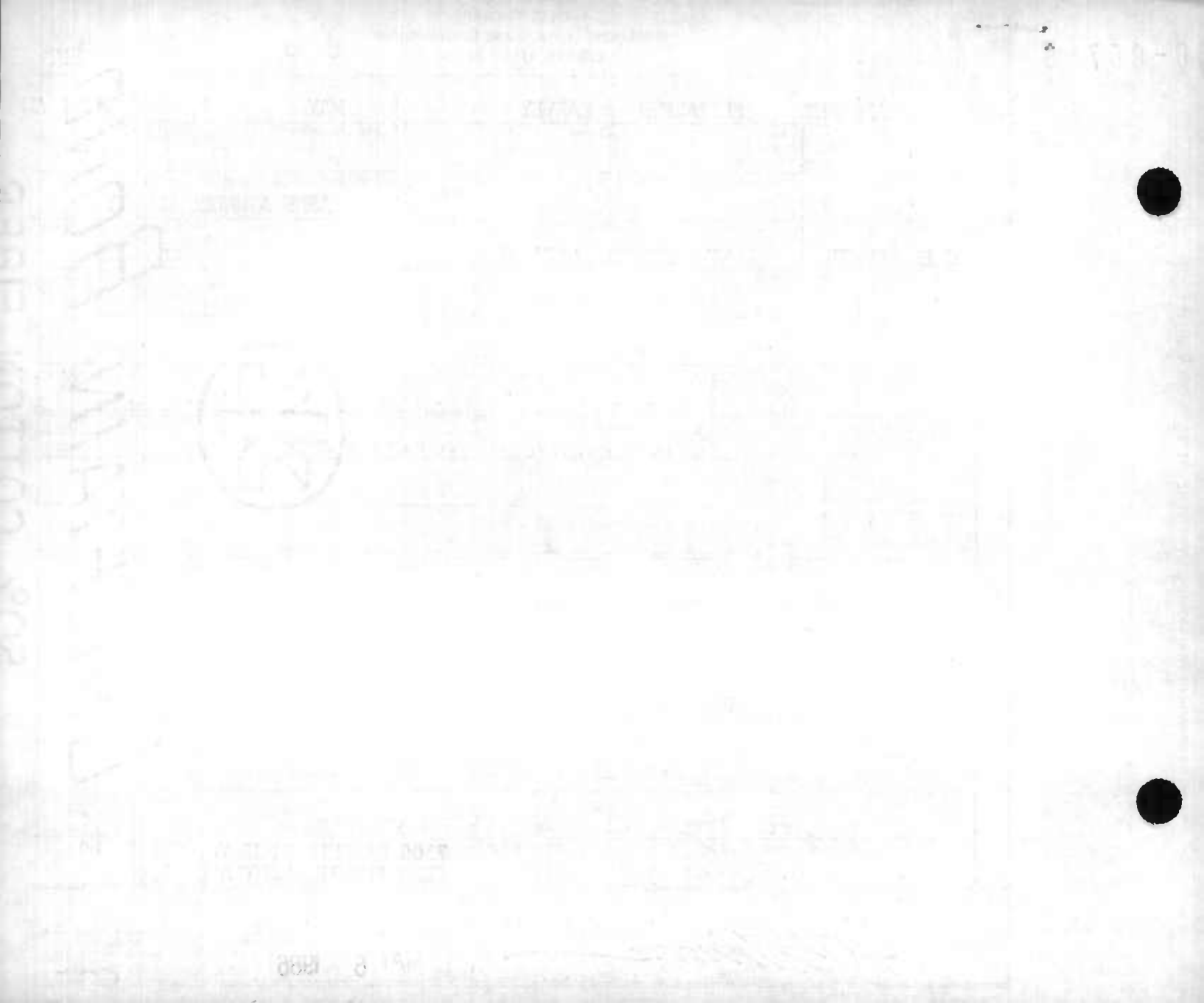
1. DECEASED NAME (TYPE OR PRINT) MARGARET ELIZABETH HARVEY			2a. DATE OF DEATH MONTH DAY YEAR MAY 1, 1986		2b. HOUR 1215 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 14 1914		
6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Cleaners		13a. STREET ADDRESS / ZIP CODE 552 Jeffrey Road 21108		
14. FATHER'S NAME FIRST MIDDLE LAST James Wilson Arnett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Norma Butler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 213.20.4257		17. INFORMANT (Son) Milton J. Harvey, III		ADDRESS 3601 Mactavish Ave. Balti., Md. 21229		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis Peritonei</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION 4/22/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinomatosis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/17/86, 19, to 4/30/86, that (I) (we) last saw the deceased alive on 4/30/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE A. Gudwin, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/1/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Gudwin, M.D.		22e. ADDRESS 7300 RITCHIE HIGHWAY, SUITE 500 GLEN BURNIE, MARYLAND 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 3, 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A A Co. Md.		24. FUNERAL DIRECTOR NAME Singleton Funeral Home Glen Burnie, Maryland				
25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE John F. [Signature]				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-08512

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

861286518  
REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAURICE J. HERBERT			2a. DATE OF DEATH MONTH DAY MAY 24, 1986		2b. HOUR 12:00 P.M.
3. SEX Male	4. RACE Caucasion	5. DATE OF BIRTH MONTH DAY YEAR 7-14-1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) Gov't Inspector U.S.D.A.		12b. KIND OF BUSINESS OR INDUSTRY
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN New York Suffolk Hauppauge			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13c. STREET ADDRESS / ZIP CODE 354 Ridgefield Rd	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Hebert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Philomena			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, FILL IN (SEE INSTRUCTIONS)) NO		16b. SOCIAL SECURITY NO. 118344735		17. INFORMANT ADDRESS Elaine Hebert (same as above)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Cardio pulmonary arrest

Acute myocardial infarction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from 5-23-86 to 5-24-86, that (I) (we) lost the deceased alive on 5-24-86, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)			
22b. SIGNATURE Ira H. Copeland M.D.		22c. DATE SIGNED 5-24-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA H. COPELAND, M.D.		22e. ADDRESS 55 AQUARIAN ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061	

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial	23b. DATE 5-28-86	23c. NAME OF CEMETERY OR CREMATORY St. Notre Dame T&W + RACKET, R.1	23d. LOCATION CITY OR TOWN COUNTY STATE Severna Park MD 21146
24. FUNERAL DIRECTOR NAME Barranco F.H. 501 Ritchie Hwy. Severna Park, MD 21146		25a. DATE REC'D. BY REGISTRAR MAY 28 1986	
		25b. REGISTRAR'S SIGNATURE John H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove card on page 3. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or filed, 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

2.

00-06573

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 6 9  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edgar A. Hepburn</b>		2a. DATE OF DEATH MONTH <b>5</b> DAY <b>12</b> YEAR <b>86</b>		2b. HOUR <b>2:55PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>3</b> YEAR <b>30</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>55</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.
10. CITY OR TOWN OF DEATH <b>Pasadena</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>714 East Shore Road (Home)</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Forklift Operator</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Pasadena</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>Silas</b> MIDDLE LAST <b>Hepburn</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Eva</b> MIDDLE LAST <b>Bradley</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>UNKNOWN</b>	17. INFORMANT <b>Katherine M. Hepburn</b> ADDRESS <b>Same as 13e</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Transitional Cell Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bladder</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2/84</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> , 19 <b>86</b> , to <b>May</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>Feb</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>James D Biles</b>	22c. ADDRESS <b>325 Hospital Drive, Dan Burre</b>		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>5/13/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial Pk</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto Md</b>	
24. FUNERAL DIRECTOR <b>George J. Gonce</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1986</b>		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/interment. Then please remove completed pages 1 and 2 and submit them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

1. Name of the person or organization to whom the letter is addressed.  
2. Address of the person or organization to whom the letter is addressed.  
3. City, State, and Zip Code of the person or organization to whom the letter is addressed.  
4. Date of the letter.  
5. Salutation (e.g., Dear Sir, Dear Madam, Dear Mr. Smith).

6. Body of the letter (the main message).  
7. Closing (e.g., Sincerely, Very truly yours, Respectfully).

8. Signature of the person sending the letter.  
9. Name and Title of the person sending the letter.  
10. Address of the person sending the letter.  
11. City, State, and Zip Code of the person sending the letter.



00-07029

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates Pages 1 and 2 should be filed with the funeral director within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GOLDIE AMANDA HILL					2a. DATE OF DEATH MONTH DAY YEAR MAY 14, 1986		2b. HOUR 145 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 1 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN BALTIMORE, FURNISH ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY A A Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Walker					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Lee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Daughter) Mrs. Patsy A. Mise		ADDRESS 807 Bunch Ave. Glen Burnie, Md. 21061				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Valvular (aortic) ; CHF, COOP</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> 19 <u>88</u> to <u>5/14</u> 19 <u>88</u> , that (I) (we) last saw the deceased alive on <u>5/14</u> 19 <u>88</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE DAVID A. SCHWARTZ, D.O.				22b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/14/88		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 17, 1986		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Md.		
24. FUNERAL DIRECTOR NAME R. Home Hopkins Singleton Funeral Home				25a. DATE RECD. BY REGISTRAR MAY 20 1986		25b. REGISTRAR'S SIGNATURE John Davidson				

00-000000

DATE: 1980 JAN 10 TIME: 14:10

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

INFO: [illegible]

NOTE: [illegible]

REFERENCE: [illegible]

ATTENTION: [illegible]

URGENT: [illegible]

ROUTED TO: [illegible]

FILED IN: [illegible]

SEARCHED: [illegible]

SERIALIZED: [illegible]

INDEXED: [illegible]

FILED: [illegible]

DATE: 1980 JAN 10

TIME: 14:10





00-06508

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

12871

1. DECEASED NAME (TYPE OR PRINT) Norman Thomas Hill Jr.			2a. DATE OF DEATH MONTH DAY YEAR May 10, 1986		2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Aug. 27, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Edgewater	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3853 Twin Oaks Rd. Ponder		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cave service mgr.	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY A.A.Co.	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Norman T. Hill Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Virginia Ruess		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) no	17. INFORMANT ADDRESS Delores J. Hill same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF KIDNEY</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>NONE</u>					
19a. DATE OF OPERATION <u>OCT 6, 1977</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMA OF KIDNEY</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 15</u> , 19 <u>77</u> , to <u>MAY 9</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>MAY 9</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>H. L. Logan Holtgrewe</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED MAY 13, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. LOGAN HOLTGREWE M.D.		22e. ADDRESS 116 MURRAY AVE ANNAPOLIS MD 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/13/86	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A.Co. Md.	
24. FUNERAL DIRECTOR NAME Hardesty Funeral HCme		ADDRESS 12 Ridgely Ave Ann. Md.		25a. DATE REC'D. BY REGISTRAR MAY 14 1986	25b. REGISTRAR'S SIGNATURE John Davidson-Randall

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. Page 1 must be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified of this.



00-07409

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 12872  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MINNIE W. HOPPER</b>			2a. DATE OF DEATH MONTH <b>05</b> DAY <b>21</b> YEAR <b>86</b>			2b. HOUR <b>10</b> <sup>PM</sup>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>02</b> YEAR <b>94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>ANNE ARUNDEL</b> 13c. CITY OR TOWN <b>CROWNSVILLE</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. STREET ADDRESS, ZIP CODE <b>Fairfield Nursing Home 21032</b> <b>1954 FAIRFIELD LOOP RD</b>				
14. FATHER'S NAME FIRST <b>CHRISTIAN</b> MIDDLE <b>HASS</b> LAST <b>HASS</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MINNIE</b> MIDDLE <b>ALT</b> LAST <b>VATER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219 32 2996</b>		17. INWARRANT ADDRESS <b>Glen Burnie, Maryland 21061</b> <b>Andrew J. Hopper Jr 502 Glen Heights Ave</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anterior myocardial infarction, and failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HEVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>May 2</b> , 19 <b>86</b> , to <b>May 21</b> , 19 <b>86</b> , that (1) (we) lost saw the deceased alive on <b>May 21</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>B.T. Furlow</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>May 22, 86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B.T. Furlow</b>				22e. ADDRESS <b>77 West St Annapolis Md 2101</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>5/24/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		23d. LOCATION <b>Glen Burnie A.A. Md.</b> STATE			
24. FUNERAL DIRECTOR <b>Raymond C. Fink Glen Burnie, Md. 21061</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 22 1986</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon of pages 1, 2, and 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-000000

RECEIVED

U.S.A.

X

AMERICAN AIRWAYS

RECEIVED

U.S.A.

X

AMERICAN AIRWAYS



2  
00-08641

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card in parentheses. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in order to perform an autopsy.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 1 2 8 7 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Vincent G. Iorio</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>5/26/86</b>				2b. HOUR <b>3:30</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05-03-1940</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1092 Magothy Circle</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manufacture RHP. Electronics</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1092 Magothy Cr./ 21401</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Vincent G. Iorio, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown -</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-52-1113</b>		17. INFORMANT ADDRESS <b>Letitia A. Iorio (same as 13)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Renal Cancer</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>3/17</b> 19 <b>86</b> , to <b>5/26</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/16</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Enser W. Cole</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/26/86</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ENSER W. COLE</b>				22e. ADDRESS <b>51 FRANKLIN ST ANNAPOLIS MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>05-29-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Barranco F.H.</b>				495 Ritchie Hwy. Severna Park, Md. 21146		25a. DATE REC'D. BY REGISTRAR <b>JUN 02 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

BP

27

975.

ਉਤੀਕ

0421-30-20

rest of the bed in

New York

[illegible]

1003 540th Circle

STANDARD

024  
025

5

• • • • •

silomera

10415 \ .70 yntons 5901

100

.3

1000

—

—

0

Spring	Winter
--------	--------

6131391 / Eff-22-074

[illegible]

153

07-29-1986 Hillcrest Cem.

Вісник

• • •

• **50**

www.ricordi.it

SECRET

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-06507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. IMPORTANT: If item 21 is marked "X", then item 22 shows any injury, or other traumatic event, which may be material to the medical examiner.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 . 1 2 8 7 4 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia Anna Jarboe										2a. DATE OF DEATH MONTH DAY YEAR 5 9 86				2b. HOUR 11:20 AM			
3. SEX female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 9 '15			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.										
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self-emp		12b. KIND OF BUSINESS OR INDUSTRY General Store							
13a. STATE Md.										13b. COUNTY A.A.Co.		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 792 Herald Harbour Rd. 21032	
14. FATHER'S NAME FIRST MIDDLE LAST Roland Lynn Cordrey					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christia Ellen Graham												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) no			17. INFORMANT ADDRESS 217-34-8413 Cornelius Jarboe same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) Multiple physiologic dysfunctions (b) DUE TO, OR AS A CONSEQUENCE OF Metastatic Cancer of the lung (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 1/2 years																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Fracture of the left humerus (Med. examiner notified 5/9/86)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. DECEASED WAS UNDERLYING <input type="checkbox"/> OR DUE TO CAUSE OF DEATH (TYPE OR PRINT) (CERTIFY MEDICAL EXAMINER) NOT WHILE AT WORK <input checked="" type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:30 P.M. 5 4 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Fall at home											
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home			21e. LOCATION STREET CITY OR TOWN COUNTY STATE 792 Herald Hb. Crownsville AA Md														
21f. I certify that (I) (this hospital) attended the deceased from 5/9/86 to present, 1986, that (I) (most) saw the deceased alive on 5/9/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.																	
22a. SIGNATURE Peter F. Verkouw					22b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 5/9/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOW					22e. ADDRESS 1833 Fredrick Drive Annapolis Md 21401												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/12/86		23c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial U.M.			23d. LOCATION CITY OR TOWN COUNTY STATE Millersville A.A. Md.									
24. FUNERAL DIRECTOR NAME Hardenstey Funeral Home 12 Ridgely ave. Ann. Md.					25a. DATE REC'D. BY REGISTRAR MAY 14 1986					25b. REGISTRAR'S SIGNATURE John Davidson-Rendell							

RECEIVED  
JAN 10 1964

10300-00





00-06555

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 7 5  
REG. NO. EDT

1- FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		WALTER C JOHNSON SR		MAY 11, 1986 510 AM	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White	9 23 08	77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL	Burner	Drydock		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
Md.	A. Arundel	Glen Burnie		7869 Crilley Rd. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Charles Johnson		Wilhelmina Selters			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-09-4853		Mrs. Virginia Johnson - Same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Terminal Carcinomatosis					
DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of lung and Liver					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Chronic Obstructive Lung Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-8-86 to 5-11-86, that (I) (we) last saw the deceased alive on 5-10-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Alejandro Montoya, M.D.				5/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
ALEJANDRO MONTOYA, M.D.		7845 OAKWOOD ROAD, SUITE 201 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Removal		5-11-86			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Anatomy Board		Balto., Md.		MAY 15 1986	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in envelope with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

*[Faint, illegible text covering the page, possibly bleed-through from the reverse side.]*



00-06070

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

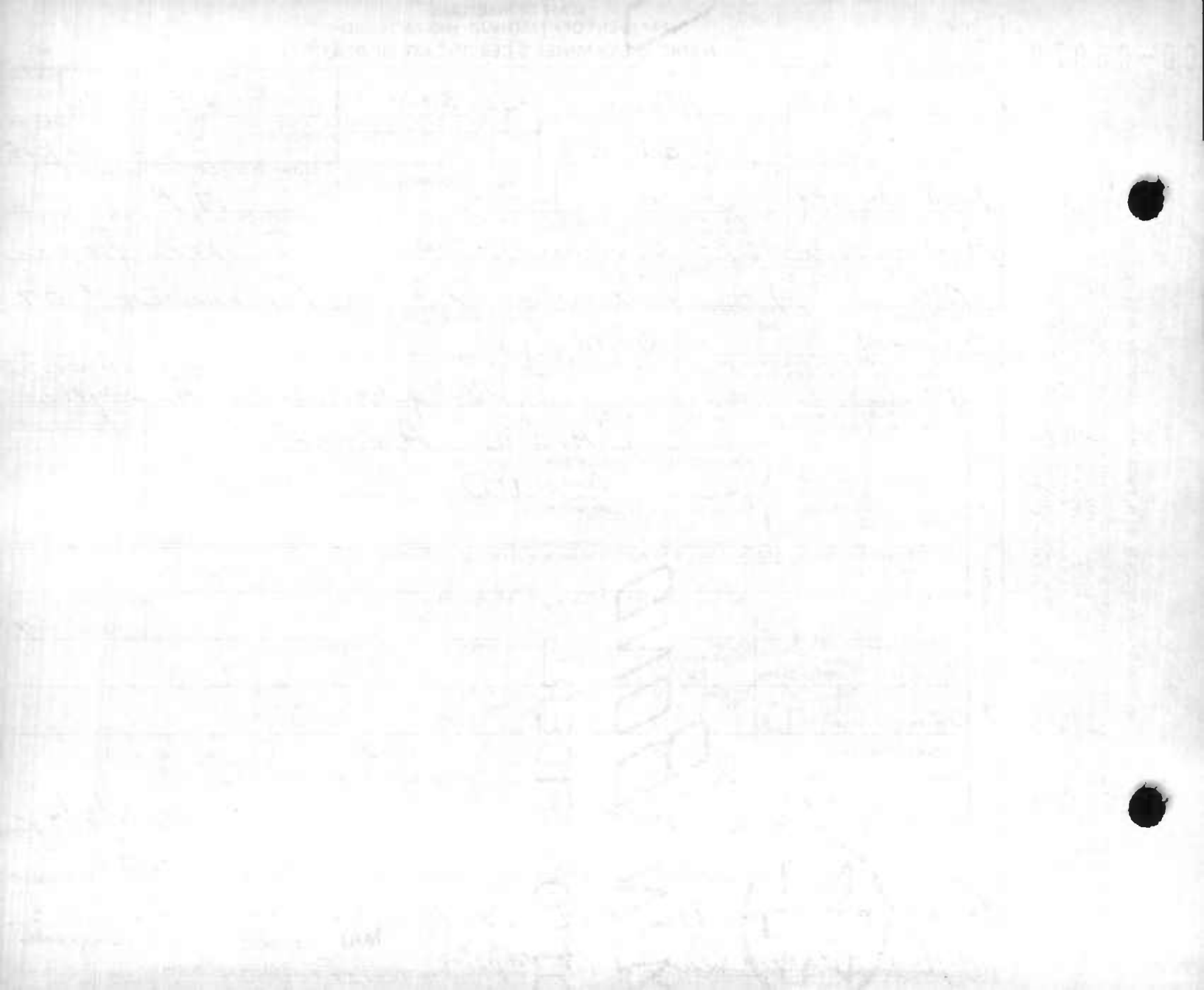
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 1 2 8 7 6

1. DECEASED NAME (TYPE OR PRINT) <b>Ethel Marie Jordan</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>5 5 1986</b>			2b. HOUR <b>1</b> M		
3. SEX <b>F</b>	4. RACE <b>Can</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 25 01</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>84</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD <b>5 5 1986</b>	2d. HOUR <b>1015</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA</b> MD		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1035 Norman Dr #107</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Md.</b>	13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1035 Norman Dr #107</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Bradley</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS <b>Wesley Neil Jordan Annapolis</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>ASCVD.</b> (b) <b>ASCVD.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>William P. Jones</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>5/6/86</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>		ADDRESS <b>695 America Crt. Davidsonville, Md. 21035</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>5/6/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG MD</b>		
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel Annapolis</b>		ADDRESS		25a. DATE RECEIVED BY REGISTRAR <b>MAY 9 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



00-09181

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 12877  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>IRIS L. KELLOUGH</b>			2a. DATE OF DEATH MONTH <b>5</b> DAY <b>28</b> YEAR <b>86</b>			2b. HOUR <b>3:30</b> PM									
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>8</b> YEAR <b>29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>						
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME MAKER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>A. A.</b> 13c. CITY OR TOWN <b>SEVERNA PARK</b>												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>802 Cypress Beach Rd 21146</b>	
14. FATHER'S NAME FIRST <b>Grason</b> MIDDLE <b>H</b> LAST <b>Standiford</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Clara</b> MIDDLE <b>M. Miller</b> LAST <b>Standiford</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>220-24-5129</b>				17. INFORMANT <b>CARROLL A Kellough (Same as #13)</b>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE Cause (a) **Myocardial Infarction**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **Craving artery disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/28/86</b> , 19, to <b>5/28/86</b> , 19, tho (I) (we) lost saw the deceased alive on <b>5/28/86</b> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. WATKINS</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/28/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. W. H.</b>				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>CREMATION</b>		23b. DATE <b>5-31-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW CREMATORY</b>		23d. LOCATION CITY OR TOWN <b>Westview</b> COUNTY <b>BALTO.</b> STATE <b>MD</b>	
24. FUNERAL DIRECTOR NAME <b>Barranco FM</b> ADDRESS <b>495 Ritchie Hwy Sev. PK MD 21146</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 05 1986</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



*[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

1287 BT

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LEVI</b> <b>KESS</b>			7a. DATE OF DEATH MONTH <b>MAY</b> DAY <b>28</b> YEAR <b>1986</b>		7b. HOUR <b>1015</b>
3. SEX <b>M</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH <b>2</b> DAY <b>13</b> YEAR <b>30</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>AAC-MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE PRINTED ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lawyer</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>			13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>MORRIS</b> MIDDLE <b>KESS</b> LAST <b>KESS</b>			15. MOTHER'S MAIDEN NAME FIRST <b>MARTHA</b> MIDDLE <b>JOHNSON</b> LAST <b>JOHNSON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-12-0362</b>	17. INFORMANT ADDRESS <b>LEAN PICKOT 4017 Broomfield Rd</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Cancer of lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>1 year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Severe COPD</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/29/86</b> to <b>5/28/86</b> , that (I) (we) last saw the deceased alive on <b>5/28/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) did (did not) see the body after death.					
22b. SIGNATURE <b>DAVID SCHWARTZ</b>				22c. DATE/SIGNED <b>5/29/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID SCHWARTZ</b>				22e. ADDRESS <b>GLEN BURNIE, MD. 21061</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>B-2-00</b>		23b. DATE <b>6/4/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT Zion</b>	
23d. LOCATION (CITY OR TOWN) <b>Parkman MD</b>		COUNTY <b>21122</b>		STATE	
24. FUNERAL DIRECTOR NAME <b>Manfred Adams 6387 S. M. ST.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 2 1986</b>		
25b. REGISTRAR'S SIGNATURE <b>John Anderson</b>					

99109-10





00-08268

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6  
REG. NO.1 2 8 7 9  
EDT

1. DECEASED NAME (TYPE OR PRINT) <b>IK Kyung KIM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 28, 1986</b>			2b. HOUR <b>437 PM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 23, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Seoul, Korea</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Korean</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>A A Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>#104 7824 Parke West Drive 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Chong Sun Kim</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ok Shin</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>			17. INFORMANT (Daughter) ADDRESS <b>Mrs. Yong Ae Hickerson Same as 13</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intrauterine Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>5-28</b> , 19 <b>86</b> , to <b>5-28</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5-28</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>SANG C. DOH, M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5-28-86</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SANG C. DOH, M.D.</b>		22e. ADDRESS <b>95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 31, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Singleton Funeral Home Glen Burnie, Maryland</b>		
25a. DATE REC'D. BY REGISTRAR <b>JUN 3 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Juan Davidson-Henderson</b>								

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 13 should be detached for use as the burial-transit permit. Then please return the completed page 13 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-06422

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove **pages 1 and 2** and deliver them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other transmission of the medical cause, the medical cause must be stated in item 18.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 8 0  
REG. NO. EDT

1. DECEASED NAME (TYPE OR PRINT) HENRY H oward KINSLEY, Sr.			2a. DATE OF DEATH MONTH DAY YEAR MAY 7, 1986			2b. HOUR 1115 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept, 14, '06	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
12. CITY OR TOWN OF DEATH GLEN BURNIE	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) City Employee		15. KIND OF BUSINESS OR INDUSTRY Balto.		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland 16b. COUNTY A. A. Co. 16c. CITY OR TOWN Severna Pk.			17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 41 Mulard Ct., 21146		
19. FATHER'S NAME FIRST MIDDLE LAST Howard Wesley Kinsley			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Armiger				
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		22. SOCIAL SECURITY NO. 216-16-8772		23. INFORMANT ADDRESS Mrs. Lillie E. Grofebert Saem as 13			
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bihemispheric Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension &amp; Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Seizure Disorder due to stroke</u>							
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
33. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		35. LOCATION STREET CITY OR TOWN COUNTY STATE			
36. I certify that (1) <u>(this hospital)</u> attended the deceased from <u>July 19 73</u> to <u>7-May 19 86</u> , that (1) <u>(we)</u> lost saw the deceased alive on <u>7-May 19 86</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>we</u> <u>(did)</u> not view the body after death.)							
37. SIGNATURE <u>Richard E. Fisher</u>				38. DEGREE MD		39. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
40. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD E. FISHER, M.D.				41. DATE SIGNED 12-May-86			
42. ADDRESS 4710 PENNINGTON AVENUE BALTIMORE, MARYLAND 21226							
43. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		44. DATE 5/10/86		45. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk.		46. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A.Co., Md	
47. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Homes 237 E. Patansco Ave. Balto., Md. 21225				48. DATE REC'D. BY REGISTRAR MAY 10 1986		49. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

ADDITIONAL MOTOR NO. 000

WILLIAM H. H. 2



00-06503

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 8 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>William H. Kohlman</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>5-7-86</u>		2b. HOUR <u>11:38</u> AM
3. SEX <u>male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>11-06-19</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>66</u> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New York</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel County</u> MD.		
10. CITY OR TOWN OF DEATH <u>Annapolis</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Electrical Eng.</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>US Government</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Anne Arundel</u> 13c. CITY OR TOWN <u>Crofton</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>1780 Regents Park Road East 21114</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>William H. Kohlmann, Sr.</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elizabeth Gorman</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u>		16b. SOCIAL SECURITY NO. <u>077-12-2448</u>		17. INFORMANT ADDRESS <u>Helen M. Kohlmann same as 13e.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 MINUTES</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u>		<u>20 MINUTES</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		<u>YEARS</u>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ADENOCARCINOMA OF PROSTATE

19a. DATE OF OPERATION <u>5/7/86</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ADENOCARCINOMA PROSTATE</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/18</u> 19 <u>86</u> to <u>5/7</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/7</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>H. Logan Holtgrewe</u> M.D.		DEGREE <u>M.D.</u>	22c. DATE SIGNED <u>5/8/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H. LOGAN HOLTGREWE</u>		22e. ADDRESS <u>16 MURRAY AVE ANNAPOLIS, MD.</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>May 12, 1986</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maryland Veterans Cem.</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Crownsville, Anne Arundel, MD</u>
24. FUNERAL DIRECTOR NAME <u>Beall Funeral Home</u>	ADDRESS <u>16000 Annapolis Road Bowie, MD 20715-3043</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 14 1986</u>

MEDICAL CERTIFICATION

100

00-05630

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

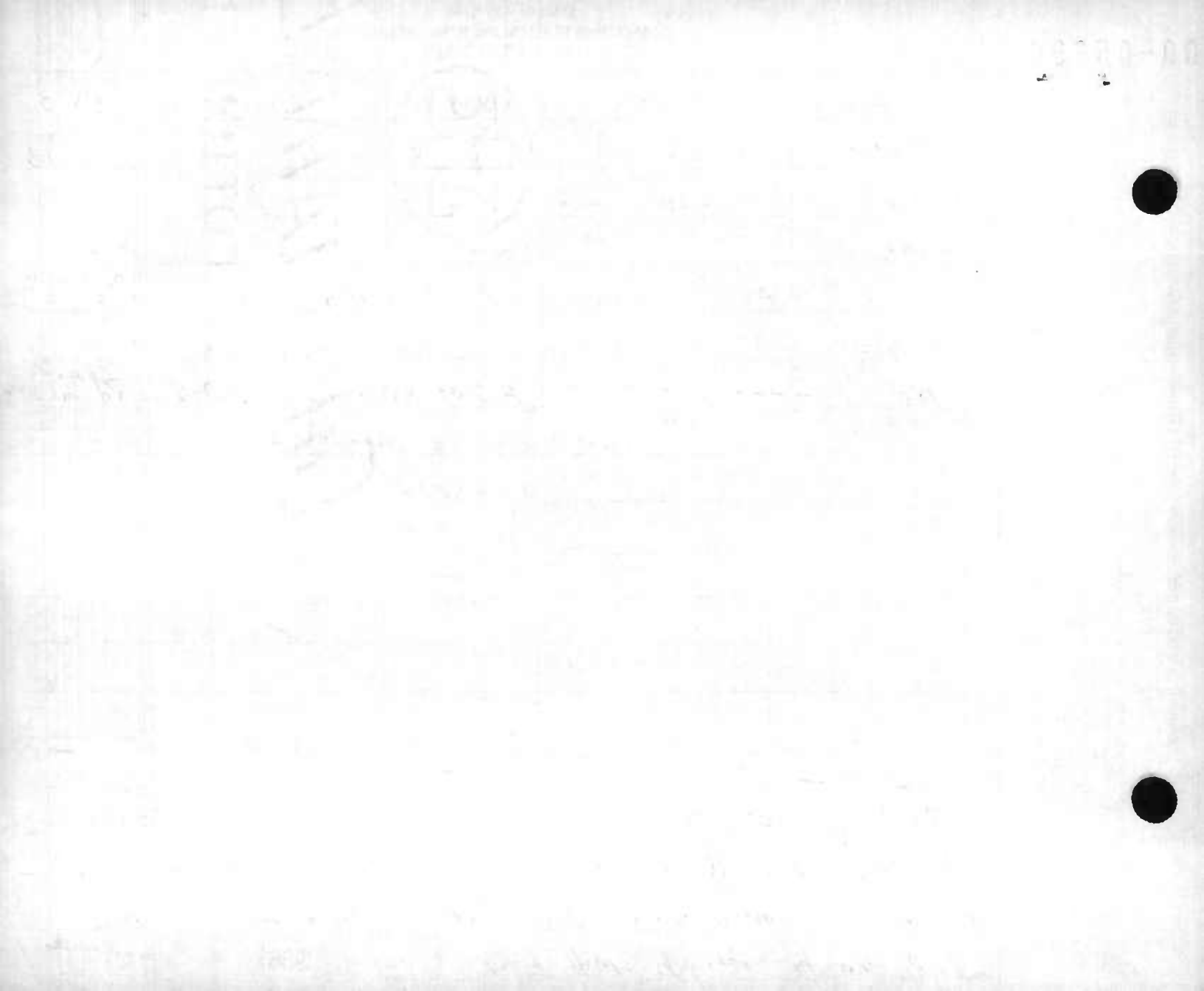
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5878.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8612882  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
ALBERT PAUL KRUMINS		05.02.86		0513M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	CAUCASIAN	MONTH DAY YEAR	0	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
USA		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
ANNAPOLIS		AA		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
ANNAPOLIS		AA-GH		R-A	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
13a. STATE COUNTY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		R-6 Pythian Rd ANN. MD 21402	
Md. AA		ANNAPOLIS			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
ALBERT		LILA SPROGIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		-----		ALBERT KRUMINS R-6 Pythian Rd ANN. MD. 21402	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) INTRAUTERINE ASPHYXIA					
DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN					
DUE TO, OR AS A CONSEQUENCE OF (c) -----					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 05.02.86 to 05.08.86, that (1) (last) saw the deceased alive on 05.02.86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Michael J. Zolenta MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		05.02.86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
MICHAEL J. LA PENTA MD		703 GIDDINGS AVE ANNAPOLIS MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		MAY 6, 1986		Westview Park	
24. FUNERAL DIRECTOR		24a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		MAY 6 1986		T. A. Handley ANNAPOLIS MD 21402	





00-07952

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return the permit to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 8 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHRYN ESTHER KUNKLE			2a. DATE OF DEATH MONTH DAY YEAR 5 22 86			2b. HOUR MIN 7 55 AM				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10- 31-1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Kensington, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 20 Loretta St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) consultant		12b. KIND OF BUSINESS OR INDUSTRY tax		
13a. STATE Md.			13b. COUNTY A.A.Co.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 20 Loretta St. 21401	
14. FATHER'S NAME FIRST MIDDLE LAST Henry A. Miller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Heckler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS 176-09-4807 Robert F. Kunkle same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (16)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 311 86 5/22 86						
22a. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> 19 <u>86</u> to <u>5/22</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/11</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (club) (did not) view the body after death.										
22b. SIGNATURE <u>Ernest W. Cole III</u>				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/22/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE III				22e. ADDRESS 51 FRANKLIN ST ANNAPOLIS Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/23/86		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory Baltimore,		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Hardesty Fun.Home 12 Ridgely Ave. Ann. Md.				25a. DATE REC'D. BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

BP

00-17023

8

1944

00-07953

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 8 8 4  
REG. NO. EDT

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
PAUL HAROLD LAFON, SR.		MAY 21, 1986		2:35 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
Male	White	March 23, 1922	64	MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH		
West Va.	USA		ANNE ARUNDEL COUNTY MD.		
12. CITY OR TOWN OF DEATH	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	15. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL	Carpenter	Construction		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
17a. STATE	17b. COUNTY	17c. CITY OR TOWN	17d. INSIDE CITY LIMITS?	17e. STREET ADDRESS / ZIP CODE	
Md.	A.A. Co.	Gambrills	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	873 Claffy Ave. 21054	
18. FATHER'S NAME			19. MOTHER'S MAIDEN NAME		
Madison LaFon			Annie Unknown		
20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		20b. SOCIAL SECURITY NO.		21. INFORMANT ADDRESS	
Yes		234-28-4727		Katherine Miller # 13e	
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE					
DUE TO, OR AS A CONSEQUENCE OF (b) SHOCK LUNG					
DUE TO, OR AS A CONSEQUENCE OF (c) ESOPHAGEAL CARCINOMA					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
LAENNEC'S CIRRHOSIS					
23a. DATE OF OPERATION		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED		23c. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b. TIME OF INJURY		24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
25a. INJURY OCCURRED		25b. PLACE OF INJURY		25c. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
26. I certify that (if this hospital) attended the deceased from 5-3-86 to 5-21-86, that (we) last saw the deceased alive on 5-21-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27a. SIGNATURE		DEGREE		27c. DATE SIGNED	
JOSE P. NEPOMUCENO, M.D.		MD		5-21-86	
28a. PHYSICIAN'S NAME (TYPE OR PRINT)		28b. ADDRESS			
JOSE P. NEPOMUCENO, M.D.		7845 OAKWOOD ROAD, #107 GLEN BURNIE, MARYLAND 21061			
29a. BURIAL, CREMATION, REMOVAL		29b. DATE		29c. NAME OF CEMETERY OR CREMATORY	
Burial		5-23-86		Lakemont	
30a. LOCATION		30b. CITY OR TOWN			
Davidsonville		A.A. Md.			
31. FUNERAL DIRECTOR		32a. DATE REC'D. BY REGISTRAR		32b. REGISTRAR'S SIGNATURE	
T.A. Hardesty		MAY 28 1986		Davidson-Randall	

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10-11-1941

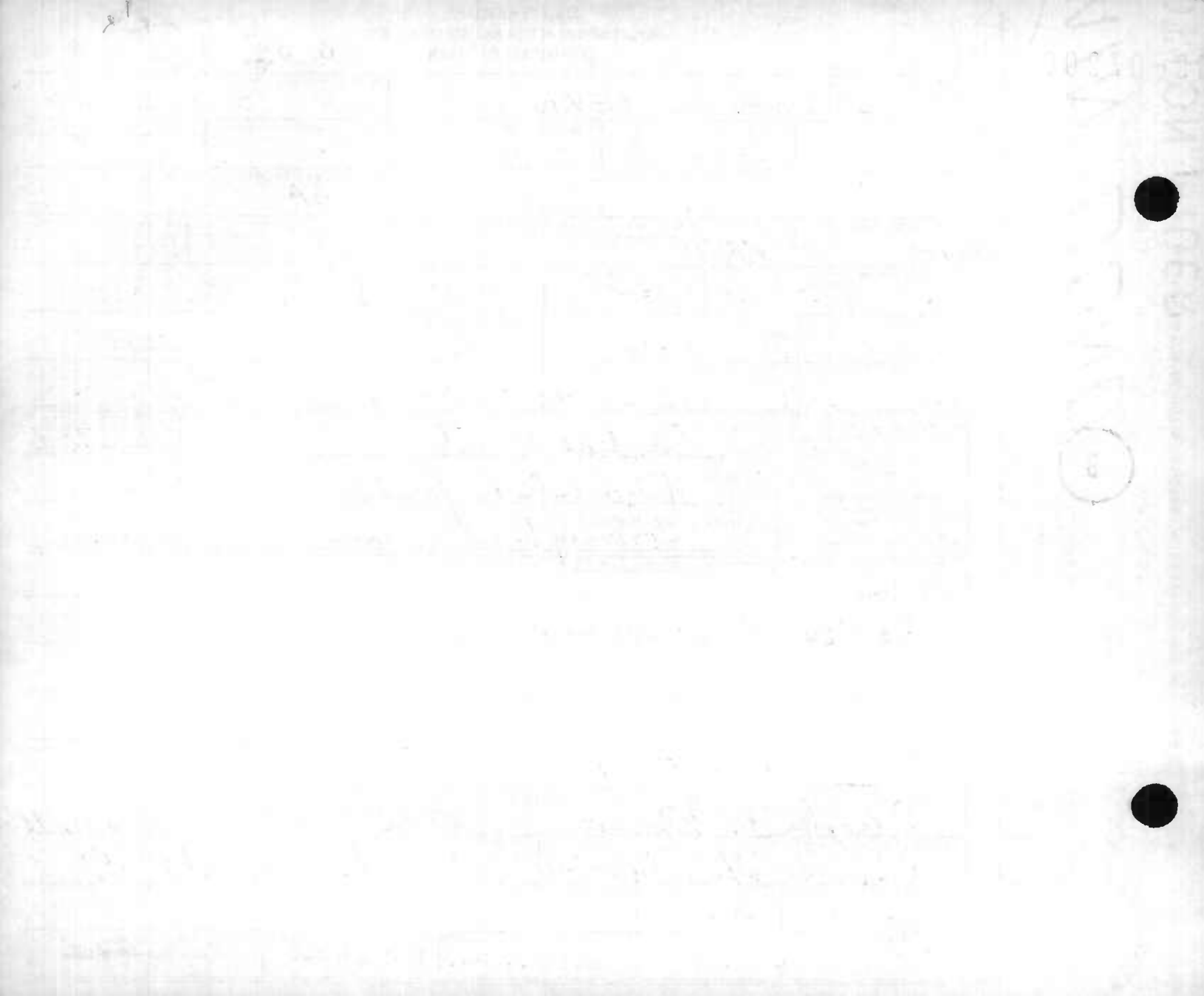
6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 6		1 2 3 8 5		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EASTMAN K LEVIN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>5 25 86</b>		2b. HOUR <b>1906</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 9 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA</b> MD.			
10. CITY OR TOWN OF DEATH <b>ANNAP.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AAGH</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Conveyer</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>A. Arundel</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1059 Lido Dr. 21401</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles J. Levin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Wilson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT <b>Charles J. Levin</b>		909 ADDRESS <b>Southwick Dr. Towson, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b>								<b>2 hours</b>	
(c) <b>Coronary heart disease</b>								<b>unknown</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>									
19a. DATE OF OPERATION <b>26 Feb 1986</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Aseptic necrosis of R. hip</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1984</b> , to <b>May 25</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>May 15</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Charles W. Kinzer</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>May 26, 1986</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles W. Kinzer</b>				22e. ADDRESS <b>MD 16 Murray Ave. Annapolis, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>5-26-86</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 28 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Davidson-Randall</b>	



00-06775

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 9 1 2 8 8 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH Jacob LICHTFUSS Sr.			2a. DATE OF DEATH MONTH DAY YEAR May 14, 1986			2b. HOUR M				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR March 17, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager- Body-Shop = Auto		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN PASADENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Johneth - Lichtfuss, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth - Reb			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W.W. II			16b. SOCIAL SECURITY NO. 214-24-5325	
17. INFORMANT ADDRESS GERTRUDE LICHTFUSS SAME AS # 13										

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). ACUTE CARDIAC STANDBILL		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours	
DUE TO, OR AS A CONSEQUENCE OF (b). Acute Stenosis		5 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c). Rheumatic HEART Disease		5 yrs.	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/17, 1986, to 5/14, 1986, that (I) (we) last saw the deceased alive on 5/15, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernie Berdawn				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-14-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNIE BERDAWN				22e. ADDRESS 606 Hammond Lane			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 17, 86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Anne Arundel, Md.	
24. FUNERAL DIRECTOR NAME McCULLY FUNERAL HOME PASADENA, MD 21122				25a. DATE REC'D. BY REGISTRAR MAY 16 1986		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove the certificate from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

MEDICAL CERTIFICATION

00000000

THE STATE OF NEW YORK

1900

mol





00-06774

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 8 7  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Mr. Melvin Frederick Linde</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 14, 1986</i>		2b. HOUR M <i>M</i>
3. SEX <i>Male</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>August 29, 1917</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.		
10. CITY OR TOWN OF DEATH <i>Linthicum</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>301 John Avenue 21090</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Salesman-Mrs. Smith Pie Co.</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF HUSBAND HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Anne Arundel</i>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE <i>301 John Avenue 21090</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John L. Linde</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dorothy Repp Baker</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-03-5003</i>		17. INFORMANT <i>Mrs. Sarah L. Linde</i> <i>301 John Avenue Linthicum, Maryland 21090</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>AS DISCUSSED WITH DR. WHEELER, MEDICAL EXAMINER</i> <i>Hypertensive Arteriosclerotic Cardiovascular Disease</i> Years DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sudden</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from <i>January</i> , 19 <i>73</i> , to <i>MAY</i> , 19 <i>86</i> , that (we) last saw the deceased alive on <i>MAY 14, 19 86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Herman Brecher</i> M.D.				22c. DATE SIGNED <i>5/16/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Herman Brecher</i>				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 17, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Baltimore MD.</i>		23e. DATE REC'D. BY REGISTRAR <i>MAY 16 1986</i>		23f. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Loring Byers Funeral Directors, Inc.</i> <i>8728 Liberty Road Randallstown, MD. 21133</i>					

MEDICAL CERTIFICATION

92

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

100-457294



MAY 18 1960

0-06071

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 12888  
REG. NO. 12888

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST		LAST	
JACK		LIVINGSTON		MAY 5, 1986 1155 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
male	White	Feb. 23, 1902		84 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Virginia	USA			ANNE ARUNDEL COUNTY MD	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Retired		Dock master
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b INSIDE CITY LIMITS?		13c STREET ADDRESS / ZIP CODE	
13a STATE 13b COUNTY 13c CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1235 Hillcreek Road 21122	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME			
Unknown		Unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES)		17. INFORMANT	
Yes		WWII 224-18-0674		Ethel Kail 1235 Hillcreek Road Pasadena, MD 21122	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARDIOPULMONARY ANNIHILATION					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) CONGESTIVE HEART FAILURE					
DUE TO, OR AS A CONSEQUENCE OF					
(c) RENAL FAILURE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 4/25, 1986, to 5/5, 1986, that (I) (last) saw the deceased alive on 5-5, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.		22b SIGNATURE		22c DATE SIGNED	
22b SIGNATURE		DEGREE		22c DATE SIGNED	
22b PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22c DATE SIGNED	
JOHN SHAVERS, M.D.		518 S. CAMP MEADE ROAD LINTHICUM, MARYLAND 21090		5/6/86	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Cremation		May 7, 1986		Cedar Hill	
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Taylor Funeral Chapel - Annapolis, MD		MAY 9 1986		Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corse papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-07949

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 8 8 9

1. DECEASED NAME (TYPE OR PRINT) <b>Robert E. MATHERS</b>			2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/>		
3 SEX <b>M</b>	4. RACE <b>Cau</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>25</b> YEAR <b>06</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>50</b>	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>00</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Edgewater</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Home Rt 2 Solomons Island</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Merchant</b>	
13a. STATE <b>md</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Edgewater</b>	
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>E</b> LAST <b>Mathers SR.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>CLARE</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PAPER Co.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>578-01-0566</b>		17. INFORMANT <b>Chester Kawakami #13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF <b>A.S.C.V.O.</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Normal Pressure Hydrocephalus Dementia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>William P. Jones</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>5/24/86</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>		ADDRESS <b>695 America Crt. Davidsonville, Md. 21035</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5-27-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulany Mem. Gardens</b>	
24. FUNERAL DIRECTOR NAME <b>T. A. Hardesty</b> ADDRESS <b>Annapolis Md. 21401</b>		23d. LOCATION FOR TOWN <b>Timonium</b> COUNTY <b>Balt</b> STATE <b>md</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 28 1986</b>	
				25b. REGISTRAR'S SIGNATURE <b>John William Haddell</b>	





00-07805

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed with the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.12890  
EDT

1. DECEASED NAME (TYPE OR PRINT) <b>FRANCES LEONIA MATTHEWS</b>			2a. DATE OF DEATH MONTH <b>MAY</b> DAY <b>23</b> YEAR <b>1986</b>			2b. HOUR <b>1233 AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>17</b> YEAR <b>1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>GLEN BURNIE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7448 Race Road Hanover, Maryland 21076</b>	
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>K.</b> LAST <b>Simms</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mamie</b> MIDDLE <b>Ann</b> LAST <b>Dublin</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>213-88-2040</b>		17. INFORMANT ADDRESS <b>Rev. Eugene W. Matthews Baltimore, Md. 21216</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/18</b> 19 <b>86</b> to <b>5/23</b> 19 <b>86</b> , that (I) (the hospital) saw the deceased alive on <b>4/18</b> 19 <b>86</b> and that in (my) <b>X</b> opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.									
22b. SIGNATURE <i>John Shavers</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>5/23/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN SHAVERS, M.D.</b>				22e. ADDRESS <b>518 CAMP MEADE ROAD LINTHICUM, MARYLAND 21090</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/27/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Rest Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Anne Arundel, Maryland</b> COUNTY STATE			
24. FUNERAL HOME OR ADDRESS <b>NOTT &amp; SONS FUNERAL HOME, INC. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 28 1986</b>		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson</i>			

MEDICAL CERTIFICATION

00-07002

1. NAME: WILLIAM A. MANNING

2. SEX: MALE

3. AGENCY: ARMY AIR FORCE

4. CLINICAL: NORTH AMERICAN HOSPITAL



5. BIRTH: 1915

6. RACE: WHITE

7. ADDRESS: 1000 14th Street, N.W., Washington, D.C.

8. OCCUPATION: Major, United States Army

9. DATE: 10/10/40

10. SIGNATURE: [Signature]

11. FILE: 100-34567





00-07485

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

12891

1. DECEASED NAME (TYPE OR PRINT) <b>Agnes</b>		FIRST <b>F.</b>		MIDDLE <b>McDONALD</b>		LAST <b>McDONALD</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 18, 1986</b>		2b. HOUR <b>8:00 PM</b>	
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 7, 1886</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>99</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>					
11. CITY OR TOWN OF DEATH <b>Crofton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Crofton Convalescent Center</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home-maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr George's</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2200 Penfield Lane 20716</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James McAtee</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Donaghue</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>179-38-6153</b>		17. INFORMANT <b>Agnes M. Russell</b>				ADDRESS <b>2200 Penfield Lane Bowie, MD 20716</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular arrest</b> DUE TO, OR AS A CONSEQUENCE OF <b>with Congestive failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Due to Natural Aging process</b> (c) <b>None</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/9 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>11/9 27 Ave 86</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>11/9 1986</b> to <b>5/12 86</b> , that (I) (we) last saw the deceased alive on <b>5/12 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If well and died not view the body after death.)											
22b. SIGNATURE <b>John J. Shigo</b>		DEGREE				22c. DATE SIGNED <b>May 19, 1986</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. John J. Shigo, M. D.</b>		22e. ADDRESS <b>Suite 209 6811 Laurel-Bowie Road Bowie, MD 20715</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>MAY 21, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rolling Green Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Camp Hill, Cumberland, PA</b>					
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>		ADDRESS <b>16000 Annapolis Road Bowie, MD 20715-3043</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 23 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Shigo</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and given.

BP

00-01412

Canada Vancouver report

MAY 23 1966

00-07327

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 1 2 8 9 2

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE OF DEATH		2d. HOUR	
Linda C. Mc Donald		5 19 1986		12:45	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Female	White	10/18/49	35	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Annapolis		Anne Arundel General Hospital		Hairdresser	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
Maryland		Anne Arundel		Crownsville	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. SOCIAL SECURITY NO.	
William Liebman		Elizabeth		214-52-8662	
16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17. INFORMANT		ADDRESS	
n/a/		John McDonald		819 oak Trail, Crownsville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Multiple Injuries					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:					
(b)					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		11:15 PM 5/19/86		Driver in auto/auto collision	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN	
		highway		Anne Arundel County, Md	
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE SIGNED	
ACTUAL SIGNATURE		M.D. Chief		May 20, 86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
John E. Smialek, M.D.		111 Penn Street, Balto, MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5/24/86		Glen Haven Cemetery	
24. FUNERAL DIRECTOR NAME		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ambrose, Inc. 1328 Sulphur Sp. Rd.		MAY 24 1986			

1907

RECEIVED



00-07384

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-M 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MEDICAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 8 9 3

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JACQUELINE JONES M<sup>RE</sup> REYNOLDS</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>5 20 19 86</b>		2b. HOUR <b>0300</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 7 1917 69</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>69</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>5 20 86</b>		7d. HOUR <b>0900</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TEXAS</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS) <b>128 E. Bay View Dr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>EDUCATOR</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOLS</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>128 E. Bay View Dr 21403</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>BERKELEY JONES</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOSEPHINE REED</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>45038 7500</b>		17. INFORMANT ADDRESS <b>WILLIAM M<sup>RE</sup> REYNOLDS #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure - acute</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>terminal event of Alzheimer's Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>- 3y</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>James S. Wheeler</b>						TITLE (SPECIFY) M.D. MEDICAL EXAMINER				DATE SIGNED <b>5/20/86</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>JAMES S. WHEELER</b>						ADDRESS <b>ANNAPOLIS MD</b>							
23a. BURIAL, CREMATION, REMOVAL (YES-IF) <b>CREMATION</b>				23b. DATE <b>5/21/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREM.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND P.G. Co. MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>TAYLOR FUNERAL CHAPEL ANNAPOLIS MD</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 22 1986</b>				25b. REGISTRAR'S SIGNATURE <b>James Davidson</b>			

8

CONFIDENTIAL

James Edgar May 1917 64  
 Texas  
 128 E. Bay View Dr.  
 Arlington, Texas  
 4203 25th Avenue NE  
 Minneapolis, MN 55412

James Edgar May 1917 64  
 128 E. Bay View Dr.  
 Arlington, Texas  
 4203 25th Avenue NE  
 Minneapolis, MN 55412

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

00-08867

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86  
REG. NO.

12894

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUTH N. MELVIN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>5 17 86</b>		2b. HOUR <b>1:15 P.M.</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 19, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INSPECTOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CHEVRON FIBERS</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. CITY OR TOWN <b>ANNAPOLIS</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JESS NEWTON NEAL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTELINE HALL</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>234-40-6382</b>		17. INFORMANT ADDRESS <b>MAXINE F. RAMEY 20 WAINWRIGHT DRIVE ANNAPOLIS, MD. 21401</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO TRACHEAL OBSTRUCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LUNG CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 YRS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Mary J. Michaels MD</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>5/18/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARY MICHAELS, MD</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>ENTOMBMENT</b>		23b. DATE <b>5-21-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST ANNAPOLIS</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNAPOLIS ANNE ARUNDEL CO. MD.</b>		23e. DATE REC'D. BY REGISTRAR <b>JUN 9 1986</b>			
24. FUNERAL DIRECTOR <b>ROBERT E. EVANS</b>		1212 WEST STREET <b>ANNAPOLIS, MARYLAND</b>		25. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>	

BP

WELSH

1911

1911

1911



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ALBERT RUSSELL MEYER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>May 13, 1986</b>			2b. HOUR <b>4:30 P</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 5 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel MD.</b>			
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>203 Wilson Blvd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance (Ret)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Air Coil</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>A A Co</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE <b>203 Wilson Blvd. 21061</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Meyer</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Von Eiff</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT (Son) <b>Mr. Allen R. Meyer</b>		ADDRESS <b>213 Drum Ave. N. Pasadena, Md. 21122</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Corcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Corcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3-17-1964</b> to <b>5-13-86</b> , that (I) (we) lost saw the deceased alive on <b>1-31-1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. Joseph Taler, M.D.</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>5-14-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Joseph Taler, M.D.</b>					22e. ADDRESS <b>95 Aquahart Road Glen Burnie, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>May 17, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A A Co. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home, Glen Burnie, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodgers</b>		

10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100

RECEIVED  
JAN 15 1952

RECEIVED  
JAN 15 1952



00-07603

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 8 9 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELSIE L. MILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5 - 18 - 86</b>		2b. HOUR <b>7:22p<sup>m</sup></b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASION</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 - 27 - 11</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF HOME, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MARYLAND</b>			13c. CITY OR TOWN <b>A.A. PASADENA</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES STINCHCOMB</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LENORA WARFIELD</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-32-0701</b>	17. INFORMANT ADDRESS <b>FREDERICK MILLER (SAME AS #13)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Embolism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Heart Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, BOTH MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <b>3-13-86</b> to <b>3-13-86</b> , that (2) over last 24 hours, the deceased gave no signs of life, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (we) did not view the body after death.					
22b. SIGNATURE <b>Arnold B. Alexander</b>		DEGREE <b>—</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARNOLD ALEXANDER</b>		22e. ADDRESS <b>RITCHIE HWY. ARNOLD, MD 21012</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>5-21-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>GLEN BURNIE A.A. MD</b>		
24. FUNERAL DIRECTOR <b>BARRANCO SEVERNA PARK MD 21146</b>		25. DATE OF REGISTRATION <b>MAY 22 1986</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked as "18" shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

11-11-1

STILL, 11-11-1

11-11-1

11-11-1

11-11-1



0-08120

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8612897  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elizabeth Teague Mills</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5-28-86</i>		2b. HOUR <i>3:25</i> M						
1. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5-08-23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.					
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Harwood</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Teague</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bessie Jones</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>							
16b. SOCIAL SECURITY NO. <i>242-38-1420</i>		17. INFORMANT <i>Stanley L Mills</i>				ADDRESS <i>Same as #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peritonitis with SSPS</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 HRS.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								DUE TO, OR AS A CONSEQUENCE OF <i>MALIGNANT ASCITES</i>		<i>1 mo</i>	
								DUE TO, OR AS A CONSEQUENCE OF <i>CARCINOMATOSIS PERITONEUM</i>		<i>6 wks</i>	
								(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>a</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Mary L Michels</i>						DEGREE <i>MD</i>		22c. DATE SIGNED <i>5/28/86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mary L Michels, M.D.</i>						22e. ADDRESS <i>51 Franklin St, Annapolis, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>May 31, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sutland P.G. MD</i>				
24. FUNERAL DIRECTOR NAME ADDRESS <i>Taylor Funeral Chapel - Annapolis, MD</i>						25a. DATE REC'D. BY REGISTRAR <i>JUN 2 1986</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

22

08PI, IE 80M

00-08117

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. The medical examiner's office may be notified if the medical examiner is notified of the death.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner's office must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 1 2 8 9 8 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>CLARA Estelle MITCHELL</b>				2a. DATE OF DEATH MONTH <b>5</b> DAY <b>24</b> YEAR <b>1986</b>				2b. HOUR <b>10 59</b> M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Feb</b> DAY <b>5</b> YEAR <b>1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saleslady</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Store</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>A.A. Pasadena</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Grover</b> MIDDLE <b>Cleveland</b> LAST <b>Sears</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Eugie</b> MIDDLE <b>Jones</b> LAST <b>Jones</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>511-425460</b>		
17. INFORMANT <b>Joanne Scheer</b>		ADDRESS <b>Same as #13</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LYMPHOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>								
19a. DATE OF OPERATION <b>5/27/86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b></b> A.M. MONTH <b></b> DAY <b></b> YEAR <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>1985</b> , 19____, to <b>5/</b> , 19____, that (we) last saw the deceased alive on <b>5/24/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Stanley A. Watkins</b>				DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/27/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STANLEY A. WATKINS</b>				22e. ADDRESS <b>51 Franklin St. Annapolis, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>		23b. DATE <b>May 28, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION CITY OR TOWN <b>Brentwood P.G.</b> COUNTY <b>MD</b> STATE <b></b>		
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel-Annapolis, MD</b> ADDRESS <b></b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 2 1986</b> 25b. REGISTRAR'S SIGNATURE <b></b>				

1. Name of the person or organization to whom the property is being transferred  
2. Date of the transfer  
3. Description of the property being transferred  
4. Signature of the person or organization transferring the property  
5. Signature of the person or organization receiving the property  
6. Notary Public's signature and seal  
7. State of the transfer



8. Name of the person or organization receiving the property  
9. Date of the transfer  
10. Description of the property being transferred  
11. Signature of the person or organization transferring the property  
12. Signature of the person or organization receiving the property  
13. Notary Public's signature and seal  
14. State of the transfer



0708036

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR		REG. NO. 86 12899			
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
FIRST MARY		F		MONTH DAY YEAR NOV 14 33		52 YRS.		4:25 P.M.	
MIDDLE LOUISE		RACE Black		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		IF UNDER 1 YEAR		IF UNDER 24 HRS	
LAST MORELAND		Black		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Md		U.S.A.		A.A.C.O.		Custodian		Public Schools	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
ANNAPOLIS		A.A. GENERAL							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13. STREET ADDRESS / ZIP CODE	
Md		A.A.		DAVIDSONVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3386 RIVA Rd 21035	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMATION ADDRESS	
FIRST LOUIS		FIRST Irene		NO		512-366808		Crotton, Md	
MIDDLE		MIDDLE							
LAST OLNEY		LAST BROWN							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
PART I. DEATH WAS CAUSED BY:		May 14, 1986		Cerebral Aneurysm		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
IMMEDIATE CAUSE (a)									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
21a. INJURY OCCURRED		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. PLACE OF INJURY		21e. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		CITY OR TOWN COUNTY STATE	
		P.M. 19							
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
May 12, 1986, to May 20, 1986, that (I) (we) lost		JACK KUSHNER MD		May 20, 1986		DUCK		20 Ridgely Ave Annapolis, MD	
saw the deceased alive on May 20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
above, (I) (we) (did) (did not) view the body after death.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
Burial		5-26-86		Md Veterans Cem		Crownsville A.A. Md		MAY 29 1986	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME C.E. Hicks III									
ADDRESS 1922 Fones Drive, Annapolis, Md									

BP.

0.008

00-07253

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed with the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit to have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury or other traumatic event, the medical examiner who has verified it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DeLores W Morris					2a. DATE OF DEATH MONTH DAY YEAR 5-12-86		2b. HOUR 2:30 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 21-1938		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Severna Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 237 Charita Ct.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-Store		12b. KIND OF BUSINESS OR INDUSTRY Hardware	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Severna Pk.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 237 Charita Ct. / 21146	
14. FATHER'S NAME FIRST MIDDLE LAST James N. White				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna N.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-34-9622		17. INFORMANT ADDRESS Wayne L. Morris Sr. (same as 13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> , 19 <u>85</u> , to <u>5/11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/30</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)									
22b. SIGNATURE Eusebio W. Colella MD				DEGREE MEDICAL ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLELLA				22e. ADDRESS 51 FRANKLIN ST ANNAP Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-14-1986		23c. NAME OF CEMETERY OR CREMATORY Hammond Cemetery		23d. LOCATION CITY OR TOWN Salisbury		COUNTY STATE Md.	
24. FUNERAL DIRECTOR NAME Barranco F.H.				495 Ritchie Hwt. Severna Park, Md. 21146		25a. DATE REC'D. BY REGISTRAR MAY 19 1986		25b. REGISTRAR'S SIGNATURE John H. ...	

MEDICAL CERTIFICATION

BP

00-07229

W

47

Dec. 21-1988

White

Female

Anne Arnold Co.

United States

Maryland

Owner-tore Hardware

Severna Park 237 Charita Ct.

237 Charita Ct. / 21145

Severna Park

A.I.

24.

H.

Anna

White

James

(same as 13) (same as 13)

230-34-0622

--

No

6

02-10-1988 Hammond Cemetery Salisbury Md.

Gravestone

404 Ritchie Hwy. Severna Park, Md. 21154 MAY 19 1988

Severna Park

00-06633

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BLANCHE SUSANNAH MUIRHEAD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 13, 1986</b>		2b. HOUR A. <b>7:43 M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>OCTOBER 15, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>PENNSYLVANIA</b>		13b. COUNTY <b>Northumberland</b>	13c. CITY OR TOWN <b>Herndon</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JEREMIAH</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE STARR</b>		13e. STREET ADDRESS / ZIP CODE <b>Box 108 RD 1 17830-99999</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577.38.6475</b>		17. INFORMANT (Daughter) ADDRESS <b>Mrs. Gloria A. Stavely 1803 Ridgewick Rd. Glen Burnie, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5/12/86 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>5/12/86</u> to <u>5/13/86</u> , that (I) (we) lost saw the deceased alive on <u>5/12/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Recep Erol</u>		DEGREE <u>MD</u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RECEP EROL, M.D.</b>		22e. ADDRESS <b>325 HOSPITAL DRIVE, #104 GLEN BURNIE, MARYLAND 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 17, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Herndon Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Herndon Northumberland Pa.</b>
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1986</b>		25b. REGISTRAR'S SIGNATURE <u>Gelia Davidson-Randall</u>	

MEDICAL CERTIFICATION

99999

BP  
DMMH: 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates Pages 1 and 2 and place them in the folder with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

8320-0





00-06473

DIVISION OF VITAL RECORDS, 201 W. PLESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate. Pages 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 12902 REG. NO.	
1. FOR REGISTRAR FOR REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR					
1. DECEASED NAME FIRST MIDDLE LAST HOWARD E MYERS, SR						MAY 5, 86 2:55 AM					
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb 10 09		6. AGE IN YEARS LAST BIRTHDAY 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Somerset, Ky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Convalescent Center						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) NAVY		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
13a. STATE Md						13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST NORRIS MYERS						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE MAE EDLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES						16b. SOCIAL SECURITY NO. W.W.11 212-30-4893		17. INFORMANT ADDRESS JANICE EASTERDAY 3264 HARNESB Creek Rd, Annapolis, Md, 21401			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia / resp. arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>terminal illness / age / stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M.				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT HOME <input type="checkbox"/> NOT WHILE AT HOME <input type="checkbox"/> AT HOME <input type="checkbox"/> AT HOME <input type="checkbox"/>				21e. PLACE OF INJURY (TRY HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22. I certify that (1) this hospital attended the deceased from <u>April 86</u> to <u>5/4</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (2) I (we) did not view the body after death.											
22a. SIGNATURE Wm Dabbs						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DABBS, W.A.						22e. ADDRESS 703 GIDDINGS AVE, ANNAPOLIS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE MAY 8. 1986		23c. NAME OF CEMETERY OR CREMATORY HILLCREST ANNAPOLIS				23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL CO MARYLAND	
24. FUNERAL DIRECTOR ROBERT E. EVANS ANNAPOLIS, MARYLAND						25a. DATE REC'D. BY REGISTRAR MAY 13 1986		25b. REGISTRAR'S SIGNATURE John F. ...			

STANDARD



NOTES

*[Faint, mostly illegible handwritten notes and bleed-through from the reverse side of the page.]*



0-05992

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completed and filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 2 9 0 3 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL AGUSTUS NEAL</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>5 1 86</b>		2b. HOUR <b>9 45 P.M.</b>			
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 1 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>HAYWOOD</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1074 CumberStone Rd 20776</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL NEAL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mima Rebecca Tydings</b>				ADDRESS <b>HAYWOOD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>218-12-9628</b>		17. INFORMANT <b>Mrs. Jessie M. Neal</b> 1074 CumberStone Rd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene of Right lower Extremity</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Peripheral Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension, Pneumonia, Uremia, Arteriosclerotic Heart</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>NO injury</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/1/86</b> to <b>5/1 1986</b> that (I) (we) lost saw the deceased live on <b>5/1/86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>C.H. Wirth M.D.</b>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/2/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.H. Wirth M.D.</b>				22e. ADDRESS <b>Lothian Md 20711</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>May 5-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chews</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>QWENSVILLE AA MD</b>					
24. FUNERAL DIRECTOR NAME <b>C.S. Hicks III</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1986</b>				25b. REGISTRAR'S SIGNATURE <b>J. Davidson</b>			

A.2.1. N 6M

NO	—	918-12-0228 Mrs. Jessie M. Neal 1044 Cumberland Rd	HAVERHILL	WIMB	1044 Cumberland Rd 2002
2	—	918-12-0228 Mrs. Jessie M. Neal 1044 Cumberland Rd	HAVERHILL	WIMB	1044 Cumberland Rd 2002
3	—	918-12-0228 Mrs. Jessie M. Neal 1044 Cumberland Rd	HAVERHILL	WIMB	1044 Cumberland Rd 2002
4	—	918-12-0228 Mrs. Jessie M. Neal 1044 Cumberland Rd	HAVERHILL	WIMB	1044 Cumberland Rd 2002
5	—	918-12-0228 Mrs. Jessie M. Neal 1044 Cumberland Rd	HAVERHILL	WIMB	1044 Cumberland Rd 2002
6	—	918-12-0228 Mrs. Jessie M. Neal 1044 Cumberland Rd	HAVERHILL	WIMB	1044 Cumberland Rd 2002
7	—	918-12-0228 Mrs. Jessie M. Neal 1044 Cumberland Rd	HAVERHILL	WIMB	1044 Cumberland Rd 2002
8	—	918-12-0228 Mrs. Jessie M. Neal 1044 Cumberland Rd	HAVERHILL	WIMB	1044 Cumberland Rd 2002
9	—	918-12-0228 Mrs. Jessie M. Neal 1044 Cumberland Rd	HAVERHILL	WIMB	1044 Cumberland Rd 2002
10	—	918-12-0228 Mrs. Jessie M. Neal 1044 Cumberland Rd	HAVERHILL	WIMB	1044 Cumberland Rd 2002

C. S. Hicks in 1907 forest Dept  
made the discovery and  
Burrill

overlaid it A H Burrill

00-07484

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO. 12904

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR		2b HOUR		
Nellie C. Nelms					May 15, 1986		M		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Caucasian		Aug. 15, 1901		84 YRS		IF UNDER 24 HRS HOURS MIN.	
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD	
Virginia		USA				Anne Arundel			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Crofton		Crofton Convalescent Center				Homemaker			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE	
Maryland		Prince Georges		Bowie				12803 Chesney Lane 20715	
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16 ADDRESS			
William B. Winfree				Sadie Turner		12800 Chesney Lane Bowie, Maryland			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
no		227-66-5818		Andy S. Hynes, Jr.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the bladder</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>MARCH 1</u> , 19 <u>86</u> , to <u>MAY 15</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>MAY 9</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
22b SIGNATURE <u>Neil J. Johnson</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <u>5/15/86</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>NEWMAN G. GOODMAN</u>				22e ADDRESS <u>3231 Superior Lane Bowie 21705</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Transit burial		May 17, 1986		Forest Lawn Cemetery		Norfolk, Norfolk, Virginia			
24 FUNERAL DIRECTOR NAME		16000 Annapolis Rd ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Beall Funeral Home		Bowie, Maryland		MAY 23 1986		<u>John Anderson</u>			

MEDICAL CERTIFICATION

229

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical examiner with the health department should be called.

1000

00-08024

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 9 0 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna T. Neville			2a. DATE OF DEATH MONTH DAY YEAR 5 26 86			2b. HOUR 2:15P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 29 18		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5404 Ballman Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly Line		12b. KIND OF BUSINESS OR INDUSTRY Venetian Blinds	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5404 Ballman Avenue 21225	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Stayer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Serec					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-10-6452		17. INFORMANT ADDRESS Bonnie Kogler 429 Prince St Balto Md 21225					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cholesterol in Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/18/86, to 5/26/86, that (I) (we) lost saw the deceased alive on 5/22/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Benjamin Berdann						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/27/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Berdann M.D.						22e. ADDRESS 606 Hammonds Lane Baltimore, Maryland 21225			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/29/86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md		
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md						25a. DATE REC'D. BY REGISTRAR MAY 29 1986		25b. REGISTRAR'S SIGNATURE John Davidson	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-08437

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 2 9 0 6 REG. NO. EDT	
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN . NICHOLS</b>					2a. DATE OF DEATH MONTH <b>MAY</b> DAY <b>28</b> YEAR <b>1986</b>			2b. HOUR <b>450 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>29</b> YEAR <b>29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. IF UNDER 72 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN ENOUGH SPACE, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Paving</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>A.A.</b> 13c. CITY OR TOWN <b>Odenton</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1590 Annapolis Road 21113</b>				
14. FATHER'S NAME FIRST <b>Joe</b> MIDDLE <b></b> LAST <b>Nichols</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Maggie</b> MIDDLE <b></b> LAST <b>Magill</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>209-26-6632</b>		17. INFORMANT ADDRESS <b>Deloris Nichols Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Hypoxia Brain Damage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARDS &amp; Respir Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b> <b>5 Days</b> <b>2 wks</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>Liver Failure, Kidney Failure, Septic Shock.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/28</b> 19 <b>86</b> to <b>5/28</b> 19 <b>86</b> , that (I) (we) last saw the deceased on the <b>28</b> day of <b>May</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.											
22b. SIGNATURE <b>David A. Schwartz</b> DEGREE										22c. DATE SIGNED <b>5/28/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID A. SCHWARTZ, D.O.</b>					22e. ADDRESS <b>7845 OAKWOOD ROAD, SUITE 200 GLEN BURNIE, MARYLAND 21061</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/30/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Collingdale</b> COUNTY <b>Delaware</b> STATE <b>Pa.</b>			
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hgwy Balto Md</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 4 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Darden</b>			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 9 0 7  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilbert Walenty Nowakowski			2a. DATE OF DEATH MONTH DAY YEAR May 11, 1986		2b. HOUR A M
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 22, 1916	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) Balto., Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH Severn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7952 Telegraph Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Die Operator (ret)		12b. KIND OF BUSINESS OR INDUSTRY Ametek
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A A Co.	13c. CITY OR TOWN Severn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Walenty Nowakowski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Apollinia Hoppa		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) //////	17. INFORMANT (Wife) Mrs. Sophie Nowakowski	ADDRESS Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA of Lung = mets</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/29/86</u> 19 <u>86</u> to <u>5/11</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>3/24</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. Marc Kaplan</u>		DEGREE MD		22c. DATE SIGNED 5/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Marc Kaplan, M.D.		22e. ADDRESS Suite 200 21061 7845 Oakwood Rd., Glen Burnie, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 14, 1986	23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Field		23d. LOCATION CITY OR TOWN COUNTY STATE Millersville A A Co. Md.	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 13 1986	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

RECEIVED



YAM

00 - 06377

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 9 0 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Evelyn M. Orme			2a. DATE OF DEATH MONTH DAY YEAR 5/6/86			2b. HOURS 10:55 P.M.			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12-5-1907		6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Household	
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Churchton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 5611 Dover St. Franklin Manor 20733	
14. FATHER'S NAME FIRST MIDDLE LAST Ansel R. Davis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-34-0350		17. INFORMANT ADDRESS Earle T. Orme Sr. same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hours 10 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Stroke									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/13 19 86 to 5/6 19 86, that (I) (we) last saw the deceased alive on 5/6 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stuart E. Selowick, M.D.						DEGREE M.D.		22c. DATE SIGNED 5/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selowick, M.D.						22e. ADDRESS 51 Franklin St. Annapolis, Md. 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/9/86		23c. NAME OF CEMETERY OR CREMATORY Woodfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Galesville A.A. Co. Md.			
24. FUNERAL DIRECTOR Hardesty Funeral Home				25. ADDRESS 12 Ridgely Ave. Annapolis, Md. 21401		25a. DATE REC'D. BY REGISTRAR MAY 13 1986		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "I" shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



11

11

11

11

11

11

00-07381

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 2 9 0 9

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth S. OVEREND			2a. DATE OF DEATH MONTH DAY YEAR 5 16 86			2b. HOUR 3 P.M.						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 08 19		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.						
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN.				12a. USUAL OCCUPATION (NAME OF WORK OR MOST OF WORKING LIFE) SECT		12b. KIND OF BUSINESS OR INDUSTRY STATE of MD.				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY AA		13c. CITY OR TOWN SHERWOOD Forest		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 239 NOTTINGHAM Hill 21405			
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS STEVENSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE ANNIE McCANN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 133053160		
17. INFORMANT ADDRESS JOHN W. OVEREND # 13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>5-16-1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Robert T Peterson MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-17-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert T Peterson						22e. ADDRESS 25 SHAW ST. Annapolis MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 5/17/86		23c. NAME OF CEMETERY OR CREMATORY CEDAR Blk		23d. LOCATION CITY OR TOWN COUNTY STATE SOUTHARD P.G. MD.					
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL						ADDRESS Annapolis, MD.		25a. DATE REC'D. BY REGISTRAR MAY 22 1986			25b. REGISTRAR'S SIGNATURE Richard Davidson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transfer permit. Then please return carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. Name of the plant or animal  
2. Date of collection  
3. Locality  
4. Collector's name  
5. Number of specimens  
6. Remarks



7. Description of the specimen  
8. Date of examination  
9. Name of the examiner  
10. Remarks

00-08115

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 2 9 1 0

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lily D. Page		2a. DATE OF DEATH MONTH DAY YEAR 5-24-86		2b. HOUR 05 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 2, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Edgewater	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living C. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD	13b. COUNTY A.A.	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1441 Pine Whiff Avenue 21037	
14. FATHER'S NAME FIRST MIDDLE LAST Henry A. Dammeyer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elise Fallbush			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-262988		17. INFORMANT ADDRESS Same as #13	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Heart Failure  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Charles W. Kinzer	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/24/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kinzer, M.D.		22e. ADDRESS 16 Murray Ave, Annapolis, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 27, 1986	23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff	23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		25a. DATE REC'D. BY REGISTRAR JUN 2 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove copies of pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, a medical examiner must be notified at once.

MEDICAL CERTIFICATION





0-05752

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. (WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.)

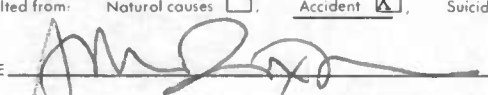
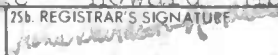
BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

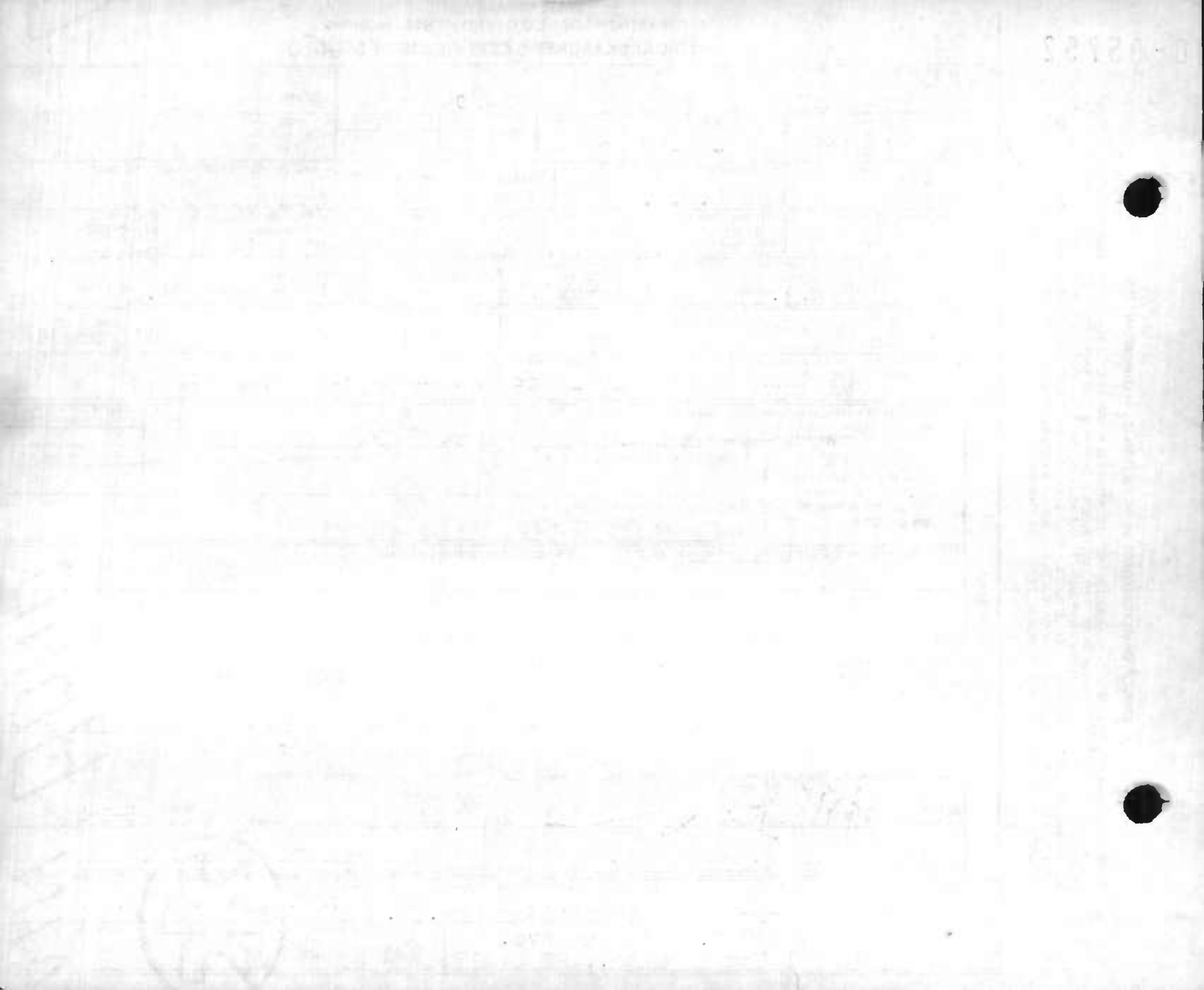
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 9 1 1

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>STEVEN EARL PARDOE</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5 1 1986</b>			2b. HOUR <b>9:40 AM</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>06-22-57</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>28 YRS</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>5 1 1986</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>		
10. CITY OR TOWN OF DEATH <b>Severna Park</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Benfield &amp; Jumpers Hole Rds.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Propane, Inc</b>
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>MD</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Millersville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>525 Pembroke Ct. 21108</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Norman Pardoe</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maristella O'Donnell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes Vietnam</b>			16b. SOCIAL SECURITY NO. <b>220-70-0466</b>		17. INFORMANT ADDRESS <b>Norman Pardoe Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thermal injury and smoke inhalation</b> <b>8160</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8:41xx 5-1- 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of truck that lost control with subsequent fire.</b>			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Benfield &amp; Jumpers Hole Rds., Anne Arundel, MD</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquest <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 			TITLE (SPECIFY) <b>M.D. Assistant</b>			DATE SIGNED <b>5-2-86</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>			ADDRESS <b>111 Penn St., Balto., MD 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5-5-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard MD</b>	
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b>			ADDRESS <b>237 E Patapsco Ave. Balto., MD 21225</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 6 1986</b>		25b. REGISTRAR'S SIGNATURE 

0-02123



BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place the certificate in the envelope with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

00-08323

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>LAST</b> <b>FIRST</b>		8 6 1 2 9 1 2 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>PARKER John</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>5 25 86</b>							
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 10 1921</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	2b. HOUR <b>M</b>						
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.							
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						
12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>ANNAPOLIS</b>						
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>904 B Royal Street 21401</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM PARKER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTELLA PARKER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>		16b. SOCIAL SECURITY NO. <b>214-16-7543</b>							
17. INFORMANT <b>Annapolis, Md. 21403</b> <b>BRENDA L PARKER 1138 Tyler Ave.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cor Artery Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ventricular Irritability</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3-4 19 84</b>							
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>3-4 19 84</b>							
21e. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3-4 19 84 May 19 86</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>3-4 19 84</b> to <b>May 19 86</b> , that (I) (we) last saw the deceased alive on <b>3-4 19 84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) see the body after death.									
22b. SIGNATURE <b>Charles B. Reese MD</b>		22c. DATE SIGNED <b>5-27-86</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>6-2-1986</b>							
23c. NAME OF CEMETERY OR CREMATORY <b>MARYLAND VETERANS</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Crownsville A.A. Maryland</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>ANNAPOLIS, MD. 21401</b> <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>		25a. DATE REC'D BY REGISTRAR <b>JUN 3 1986</b>							
25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>									

MEDICAL CERTIFICATION

00-20372

NOTICE

NOTICE

NOTICE



0-08

NOTICE

12  
00-06423STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 9 1 3  
REG. NO. EDT

1- FOR STATE REGISTRAR		1a DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE (RABAUGH) LAST PARKS, Sr.		2a DATE OF DEATH MONTH DAY YEAR SR MAY 11, 1986		2b HOUR 0235	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 21, 1902		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10 CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING WEEK) Auto repair Store		12b KIND OF BUSINESS OR INDUSTRY Liquor Retail	
13a STATE Md.		13b COUNTY Anne Arundel		13c CITY OR TOWN Pasadena		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William - R Parks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertie Mae Fowler		13e STREET ADDRESS / ZIP CODE 8184 Riverside Drive, 21122			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-32-1216		17 INFORMANT ADDRESS Mrs. Anna E. Parks, same as 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from May 2nd, 1986, to May 11th, 1986, that (I) (we) last saw the deceased alive on May 9th, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED May 11, 86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WU M.D.		22e ADDRESS 7845 OAKWOOD RD SUITE 204 GLEN BURNIE, MARYLAND 21061					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5-15-1986		23c NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24 FUNERAL DIRECTOR Mc Cully F.H. 3204 Mountain Rd. Pasadena, Md.		25a DATE REC'D. BY REGISTRAR MAY 13 1986		25b REGISTRAR'S SIGNATURE			

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10



10/10/10

10/10/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8 6 1 2 9 1 4 REG. NO. EDT							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALVA J PARSONS						2a. DATE OF DEATH MONTH DAY YEAR MAY 22, 1986		2b. HOUR 600 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 6, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Coal Miner	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY AA 13c. CITY OR TOWN Pasadena 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE 4401 Sharon Drive 21122			
14. FATHER'S NAME FIRST MIDDLE LAST William S. Parsons						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Carey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-05-6096		17. INFORMANT ADDRESS Nettie J. Register, Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Bronchitis Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Life long Cigarette Smoking</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>20 yrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>5/4/86</u> to <u>5/22/86</u> that (I) (we) last saw the deceased alive on <u>5/4/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
22b. SIGNATURE 						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CALVIN E. FUHRMANN, M.D.						22e. ADDRESS 200 HOSPITAL DRIVE, SUITE LL-10 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 27, 1986		23c. NAME OF CEMETERY OR CREMATORY Golden Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lakewood Colorado			
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD						25a. DATE REC'D. BY REGISTRAR MAY 23 1986			
						25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

1944

NOV 2 1944

YOUNG L. B. 1944

1944

2300 DE  
2300 DE

Handwritten notes and signatures in the center of the page.



Handwritten notes and signatures at the bottom of the page.

1944



00-08285

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8 6 1 2 9 1 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) TERRI Angel PATTERSON				2a. DATE OF DEATH MONTH DAY YEAR May 31 86		2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 22 1952		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7704 Moonfall Ct.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7704 Moonfall Court 21122	
14. FATHER'S NAME FIRST MIDDLE LAST William A. Reiter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine L. Newberry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-56-9779		17. INFORMANT ADDRESS William P. Kreppel, Jr. Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Brain Tumor</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1 Year</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hypertension</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (that hospital) attended the deceased from <u>9/2</u> <u>1985</u> to <u>5/31</u> <u>1986</u> , that (I) (we) last saw the deceased on <u>5/31</u> <u>1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) see the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/3/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVID A. SCHWARTZ</u>				22e. ADDRESS <u>7845 Oakwood Rd.; GP, MD 2106</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/3/1986		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Ave. Balto Md 21222						25a. DATE REC'D. BY REGISTRAR JUN 3 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

9

0-07030

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 9 1 6  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		May		16, 1986	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		MONTH DAY YEAR		78		MONTHS DAYS		HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA		Sept. 26, 1907		A A Co.				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Millersville		Knollwood Manor		Superintendent		BG&E					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Anne Arundel		Sambrills				R.O. Box 14		21054	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter)		ADDRESS	
Samuel L. Peters		Carrie Vondrehle		No		212.05.6315		Mrs. Carolyn Davis		620 Florida Place Gambrills, Md. 21054	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO OR AS A CONSEQUENCE OF (b)		DUE TO OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		myocardial infarction		arteriosclerotic cardiovascular disease		DISEASE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from February 1985 to May 16, 1986, that (I) (we) last saw the deceased alive on April 19, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Dr. Donald C. Roane, M.D.		Attending Physician <input checked="" type="checkbox"/> Medical Director <input type="checkbox"/> Staff Physician <input type="checkbox"/>				5/16/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Dr. Donald C. Roane		1616 Forest Dr. Annapolis, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		May 19, 1986		Glen Haven Mem. Park		Glen Burnie A A Co. Md.					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Singleton Funeral Home		Glen Burnie, Maryland		MAY 20 1986							

BP

Handwritten notes and signatures are visible across the page, including a large signature in the lower left and various smaller markings and initials throughout the document.



00-06382

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 9 1 7  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Dorothy Edna Pfaff			2a. DATE OF DEATH MONTH DAY YEAR 05-06-86 4-6-86 11:25 P.M.	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 4-7-12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Q.A.	13c. CITY OR TOWN Chester	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James Anderson Wallace		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Adele Shaw		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-22-7386		17. INFORMANT Dorothy E. Schwinn
				ADDRESS same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Shock - gran negative sepsis

DUE TO, OR AS A CONSEQUENCE OF

(b)

Pneumonia sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Urinary Tract inf.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE 		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tom Helfenbein		22e. ADDRESS Stevensville Cemetery, Stevensville, Q.A., MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 05-09-86	23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Stevensville Q.A. MD
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Chester, MD 21619		25a. DATE REC'D. BY REGISTRAR MAY 13 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-08322

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 9 1 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RAYBOURN PHILLIPS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5 21 86</b>			2b. HOUR <b>5 15 A M</b>			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 27 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KENTUCKY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>P.O. Box 415 21401</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DAVID PHILLIPS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOTTIE G. RAYBOURNE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>YES W.W.II</b>		16b. SOCIAL SECURITY NO. <b>400-20-5394 A</b>		17. INFORMANT <b>Annapolis, Md. 21401 REV. FDOYD SNOWDEN 94 Clay St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Esophageal Cancer</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-18</b> , 19 <b>86</b> , to <b>death</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>1/21</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.									
22b. SIGNATURE <b>Robert T. ...</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert T. ...</b>				22e. ADDRESS <b>139 Old Solomons Ln 21401</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5-28-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD. VETERANS CE, ETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville A.A. Maryland</b>			
24. FUNERAL DIRECTOR <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 3 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John ...</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked, item 18 should only be completed if the medical examiner has been notified of the death.

BP



8



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 129 EDT?

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE BENJAMIN PHIPPS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 24, 1986</b>			2b. HOUR <b>0847 AM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 6 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Diesel Engine</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		
13a. STATE <b>Md</b>			13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Gambrills</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>927 Annapolis Rd 21054</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George W. Phipps</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minerva A. Hook</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>082-16-6971</b>			17. INFORMANT ADDRESS <b>Mary E. Phipps 927 Annapolis Rd</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF, (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Hepatic encephalopathy, ventricular arrhythmia</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>MAY 27 1986</b> , that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Basant K. Khandelwal</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>5/24/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BASANT K. KHADELWAL, M.D.</b>				22e. ADDRESS <b>7422 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-27-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md.</b>				
24. FUNERAL DIRECTOR NAME <b>T.A. Hardesty</b>				ADDRESS <b>Annapolis Md. 21401</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 28 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Anderson-Randall</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been verified by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene. Burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified.

1951-1952

1951-1952

1951-1952



1951-1952

00-08369

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2920

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Patricia B. Polk			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5/ 30/19 86			2b. HOUR 2:58 P M		
1. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 11/19/1956	6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD 5/ 30/19 86	7d. HOUR P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. STATE Md.			13b. COUNTY A.A. Co.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert E. Bailey Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty J. Orbison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 223-96-7772		17. INFORMANT ADDRESS Robert Bailey Cherry Valley Ark.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9108 IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Epileptic Seizure Disorder								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5/30/19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject drowned			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Chesapeake Bay off Sandy Point, Anne Arundel, Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
ACTUAL SIGNATURE [Signature]			DATE SIGNED 5/31/86			EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/3/86		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS HARDESTY FUNERAL HOME 12 Ridgely Ave. Annapolis, Md. 21401				25a. DATE REC'D. BY REGISTRAR JUN 4 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RW-3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

DEPT. OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 1 2 9 2 1

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT Thomas PULANCO		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-17-86 19		2b. HOUR M	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1949 37RS.	6. AGE (IN YEARS LAST BIRTHDAY) 37RS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 5-17-86 19	2d. HOUR 3:02P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH West River		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5149 Chalk Point Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dry wall		12b. KIND OF BUSINESS OR INDUSTRY construction	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY A.A.Co.		13c. CITY OR TOWN West River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 5149 Chalk Pt. Rd. 20778	
14. FATHER'S NAME FIRST MIDDLE LAST Aurelio H. Pulanco				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Patten			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Margaret M. Pulanco same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 5-18-86	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/21/86		23c. NAME OF CEMETERY OR CREMATORY Woodfield Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Galesville A.A. Md.	
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home		ADDRESS 12 Ridgely Ave. Ann. Md. 21401		25a. DATE REC'D. BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

12070-5

100  
100  
100  
100

100  
100  
100  
100



100  
100  
100  
100

100  
100  
100  
100

0-07948

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 9 2 2  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Baby Boy RHODES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5 13 86</b>			7b. HOUR <b>8:30 AM</b>							
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 13 86</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>0</b>		7a. IF UNDER 1 YEAR MONTHS DAYS <b>&lt;1</b>		7c. IF UNDER 24 HRS HOURS <b>62</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.							
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N-A</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N-A</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Anne Arundel</b> 13c. CITY OR TOWN <b>Annapolis</b>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS <b>2951 Southaven Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mark Rhoades</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANN S Unknown</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>---</b>				16b. SOCIAL SECURITY NO. <b>N-A</b>		17. INFORMANT <b>Ann G. Rhodes</b>				ADDRESS <b>#13e</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	---

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital attended the deceased from <b>5/13/86</b> , 19__, to __, 19__, that (1) (we) last saw the deceased alive on <b>5/13/86</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or we did not see the body after death).							
22b. SIGNATURE <b>Robert G. Gray Jr.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7d. DATE SIGNED <b>5/13/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT G. GRAY JR. M.D.</b>		22e. ADDRESS <b>2222 R. L. ROAD DUNDISVILLE MD 20835</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>5-16-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>T.A. Hardesty Annapolis Md. 21401</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 28 1986</b>				25b. REGISTRAR'S SIGNATURE <b>J. Hardesty</b>	

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

*[Faint, mostly illegible handwritten text and markings, possibly including a signature and date.]*





00-05331

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 1 2 9 2 3 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>MARY MCKINSEY RIdout</b>				2a. DATE OF DEATH MONTH <b>5</b> DAY <b>1</b> YEAR <b>86</b>				2b. HOUR <b>A.M.</b>
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>NOV</b> DAY <b>23</b> YEAR <b>1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN, OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>		
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>H.A. GEN. HOSPITAL</b>		12a. USUAL OCCUPATION (OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		
13a. STATE <b>MD.</b> 13b. COUNTY <b>133</b> 13c. CITY OR TOWN <b>H.A. Co. ANNAPOLIS</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME <b>FOLGER</b> 15. MOTHER'S MAIDEN NAME <b>FANNIE H. DUNGAN</b>				16. STREET ADDRESS / ZIP CODE <b>1811 WHITEHALL ROAD 21401</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>212 60 0405</b>				
17. INFORMANT <b>ORLANDO RIdout II</b>				ADDRESS <b>1021 WHITE HALL RD. ANNAPOLIS, MD. 21401</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>cardiovascular stroke</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>19</b> DAY <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN, COUNTY, STATE)				
22a. I certify that (I) (this hospital) attended the deceased from <b>April 26</b> 19 <b>86</b> to <b>April 30</b> 19 <b>86</b> , that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>A. Plucis</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/1/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. Plucis</b>				22e. ADDRESS <b>1521 Ritchie Hwy Annapolis, Md. 21012</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/3/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WHITE HALL CEMT.</b>		23d. LOCATION (CITY OR TOWN, COUNTY) <b>ST. MARGARETS AA MD.</b>		
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 1 1986</b>				
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>								



00-07556

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 1 2 9 2 4

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert Robinson</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>XX</b> 5-23 19 86			2b. HOUR 4:15 p.m.			
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 26, 1941</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>45</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>5-23 19 86</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>New Ordinance &amp; Blades Roads</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>trucking</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Hanover</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6322 Winters Lane 21076</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James N. Robinson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vera Patterson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Vietnam</b>		17. INFORMANT ADDRESS <b>Kenneth R. Robinson 21076 6322 Winters Lane</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Carbon Monoxide Intoxication</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY (est.) HOUR A.M. MONTH DAY YEAR <b>? P.M. 5-23 19 86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>inhaled exhaust fumes from auto</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>auto</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>New Ordinance &amp; Blades Rds., Anne Arundel Co., Maryland</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) <b>Asst. Medical Examiner</b>			DATE SIGNED <b>5-24-86</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>			ADDRESS <b>111 Penn St., Balto., Md. 21201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>			23b. DATE <b>5/24/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto. Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Ambrose Funeral Home</b>			ADDRESS <b>1328 Sulphur Spring Road</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 26 1986</b>		25b. REGISTRAR'S SIGNATURE <i>Davidson</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M
 BP \_\_\_\_\_  
 DHMH - 17  
 (VR A15 ME (5))

2025 COTTON FIBER

WELFARE



00-08939

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6  
REG. NO.

1 2 9824

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Phyllis E. Roeder</i>			2a DATE OF DEATH MONTH DAY YEAR <i>5 21 86</i>		2b HOUR <i>7:30</i> M		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Dec. 26, 1910</i>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>75</i> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Canada</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.	
10 CITY OR TOWN OF DEATH <i>Annapolis</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hosp.</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <i>Maryland</i>		13b COUNTY <i>Anne Arundel</i>		13c CITY OR TOWN <i>Deale</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET ADDRESS / ZIP CODE <i>422 East Bayfront Dd. 20751</i>		14 FATHER'S NAME FIRST MIDDLE LAST <i>William H. Bathe</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maude Graham</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>042-30-7351</i>		17 INFORMANT ADDRESS <i>Marjorie Bathe same as # 13</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>rupture of I. bleeding</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>advanced atherosclerotic cardiovascular disease 20 yrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>very advanced dementia</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-4 days</i>	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>12</i> 19 <i>85</i> to <i>5</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>5/20</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Paul B. Berez</i>				DEGREE <i>MD</i>		22c DATE SIGNED <i>9/20/86</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul B. Berez MD</i>				22e ADDRESS <i>1645 Defense Highway Box 3491</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b DATE <i>5 24 86</i>		23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem.</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Suitland PG Maryland</i>	
24 FUNERAL DIRECTOR NAME <i>Kausch Funeral Home</i>				25a DATE REC'D. BY REGISTRAR <i>MAY 29 1986</i>		25b REGISTRAR'S SIGNATURE <i>Dr. Paul B. Berez</i>	

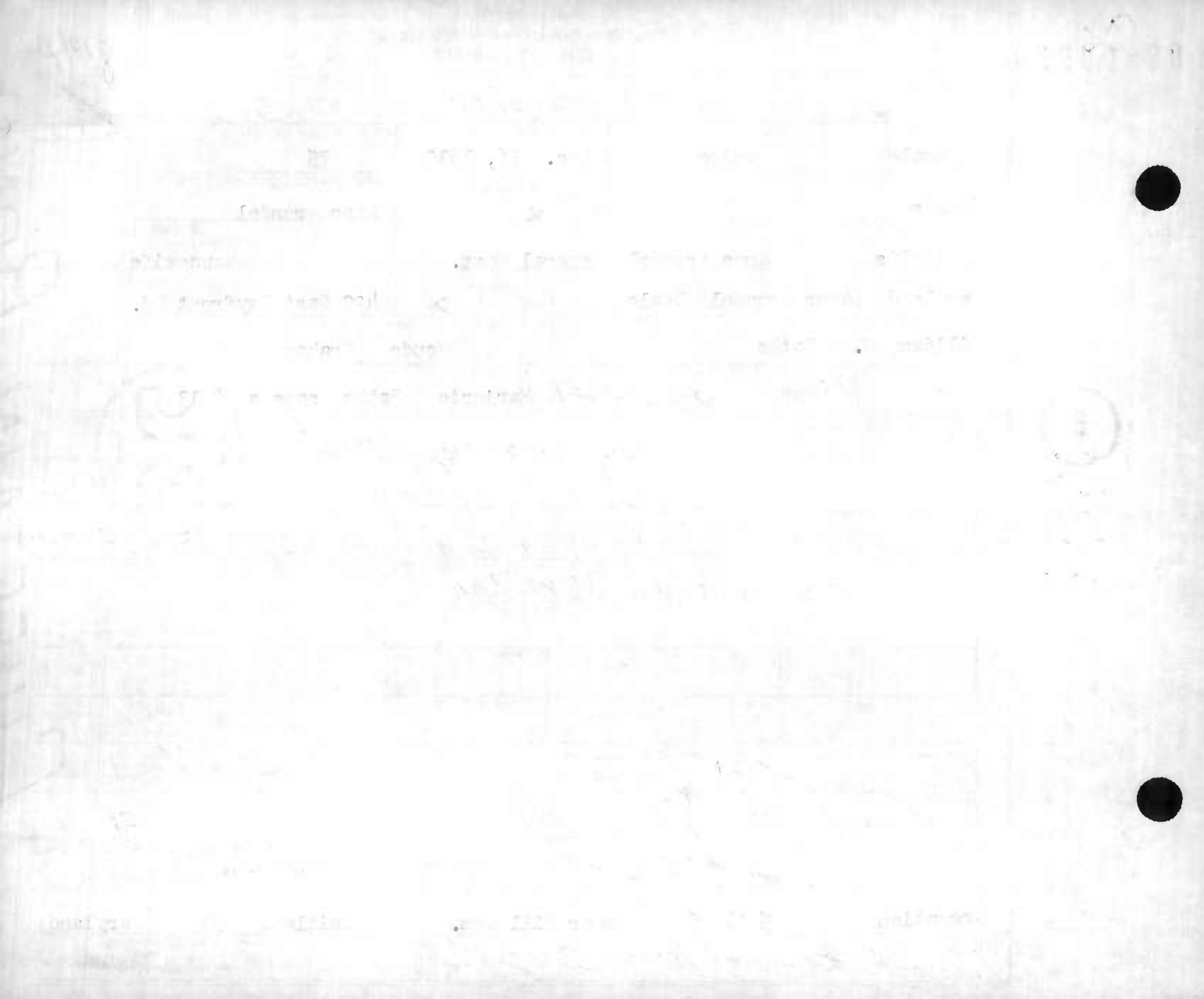
MEDICAL CERTIFICATION

93  
53  
33  
020  
9  
9  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



-06067

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 2 9 2 6 REG. NO.			
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charles C. Rose, Sr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>May 6 1986</b>				2b. HOUR <b>A. M.</b>			
3. SEX <b>male</b>		4. RACE <b>(white)</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 12, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.							
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1143 Mainsail Drive</b>						12a. USUAL OCCUPATION (IF WORK FOR MOST OF WORKING LIFE) <b>Office Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Heavy machinery</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1143 Mainsail Drive 21403</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Ernest Rose</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Estelle Dunlap</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>331-01-4489</b>		17. INFORMANT ADDRESS <b>Charles C. Rose, Jr. 1143 Mainsail Drive Annapolis, MD 21403</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>10 YEARS</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>-</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/27 1986 P.M.</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <b>4/27</b> 19 <b>86</b> , to <b>4/27</b> 19 <b>86</b> , that (2) (we) last saw the deceased alive on <b>4/27</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (2) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Robert Scott Eden</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/6/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT SCOTT EDEN</b>						22e. ADDRESS <b>703 GIDDINGS AVE, ANNAPOLIS, MD 21401</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>May 10, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Eden Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Livonia Wayne MI</b>					
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel - Annapolis MD</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 9 1986</b>							
						25b. REGISTRAR'S SIGNATURE <b>Wayne</b>							



On the 1st of June 1864  
I received from you  
a letter of the 28th inst.  
in relation to the  
matter of the  
estate of the late  
John H. Smith  
deceased  
and in reply to inform  
you that the same  
has been referred  
to the proper  
authorities for  
their consideration  
and that they will  
be ready to  
act on the same  
at the next  
meeting of the  
Board of Directors  
of the  
Company.

Very respectfully,  
Your obedient servant,  
J. H. Smith  
President of the  
Company



00-06897

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

12927

1. DECEASED NAME (TYPE OR PRINT) <b>MARGUERITE</b>			FIRST MIDDLE LAST <b>SALTZMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5/8/86</b>			2b. HOUR <b>12 MA</b>		
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>9-3-1911</b>			6. AGE (IN YEARS (LAST BIRTHDAY)) <b>74</b> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE Arundel MD</b>		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Anne Arundel Gen.</b>			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>A.A.</b>			13c. CITY OR TOWN <b>Severna Pk</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Joseph Kroth</b>			14. MOTHER'S NAME FIRST MIDDLE LAST <b>Anna C. Davis</b>			15. ADDRESS <b>William Saltzman (SAME AS ABOVE)</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES) <b>214-24-4261</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary fibrosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic</b> Approximate interval between onset and death <b>2 years</b>									PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic ulcer with massive bleeding</b>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5/27/86</b> <b>5/8</b> <b>86</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>5/27/86</b> <b>5/8</b> <b>86</b> <b>MD</b>			21g. I certify that (I) (this hospital) attended the deceased from <b>5/27/86</b> to <b>5/8/86</b> , that (I) (we) last saw the deceased on <b>5/8/86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not see the body after death.			22a. SIGNATURE <b>[Signature]</b> DEGREE <b>MD</b>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT)			22c. ADDRESS			22d. DATE SIGNED <b>5/8/86</b>			22e. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5-10-86</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem</b>			23d. LOCATION OR TOWN COUNTY STATE <b>Glen Burnie, FA MD</b>		
24. FUNERAL DIRECTOR NAME <b>Barranco F.H.</b>			25. DATE REC'D. BY REGISTRAR <b>MAY 15 1986</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			25c. REGISTRAR'S NAME <b>Julia [Signature]</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

1. The purpose of this report is to provide a summary of the results of the investigation conducted during the period from January 1, 1961, to December 31, 1961.

2. The investigation was conducted in accordance with the plan of work approved by the Joint Committee on the Organization of the Executive Branch of the Government, dated June 1, 1960.

3. The results of the investigation are summarized in the following sections:

4. The first section, "Introduction," discusses the background of the investigation and the objectives of the study.

5. The second section, "Methodology," describes the methods used to collect and analyze the data.

6. The third section, "Results," presents the findings of the investigation.

7. The fourth section, "Conclusions," discusses the implications of the findings and offers recommendations for future research.

8. The fifth section, "References," lists the sources of information used in the study.

5

9. The investigation was conducted by the following personnel:

10. The results of the investigation are summarized in the following sections:

11. The first section, "Introduction," discusses the background of the investigation and the objectives of the study.

12. The second section, "Methodology," describes the methods used to collect and analyze the data.

13. The third section, "Results," presents the findings of the investigation.

14. The fourth section, "Conclusions," discusses the implications of the findings and offers recommendations for future research.

15. The fifth section, "References," lists the sources of information used in the study.

16. The investigation was conducted by the following personnel:

17. The results of the investigation are summarized in the following sections:

18. The first section, "Introduction," discusses the background of the investigation and the objectives of the study.

19. The second section, "Methodology," describes the methods used to collect and analyze the data.

20. The third section, "Results," presents the findings of the investigation.

21. The fourth section, "Conclusions," discusses the implications of the findings and offers recommendations for future research.

22. The fifth section, "References," lists the sources of information used in the study.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8612928  
REG. NO.

FOR 1. STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) MILLIE O. SANTORO				2. DATE OF DEATH MONTH DAY YEAR 5 4 86				2b. HOUR 6:45 AM	
3. SEX Female		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 02 13 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Mother	
13a. STATE Md.				13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Howard Allred				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Mc Gowan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Charles Phillips (same as 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Small Cell Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Emphysema									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/21 19 86, to 5/4 19 86, the (I) (we) lost saw the deceased alive on 5/3 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE Emser W. Cole II				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ENSER W. COLE II				22e. ADDRESS 51 FRANKLIN ST ANNAPOLIS Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-6-1986		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Shreveport La.			
24. FUNERAL DIRECTOR NAME Barranco F.H. Severna Park, Md. 21146				25a. DATE REC'D. BY REGISTRAR MAY 5 1986		25b. REGISTRAR'S SIGNATURE John Twicken			

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. 1st of Jan.

2. 2nd of Jan.

3. 3rd of Jan.

4. 4th of Jan.

5. 5th of Jan.

6. 6th of Jan.

7. 7th of Jan.

8. 8th of Jan.

9. 9th of Jan.

10. 10th of Jan.

11. 11th of Jan.

12. 12th of Jan.

13. 13th of Jan.

14. 14th of Jan.

15. 15th of Jan.

16. 16th of Jan.

17. 17th of Jan.

18. 18th of Jan.

19. 19th of Jan.

20. 20th of Jan.

00 to 07223

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 9 2 9  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH M. SCHOLTZ		MONTH DAY YEAR 5 11 86		3:45 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 15 02		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Severna Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY A. Arundel	13c. CITY OR TOWN Arnold	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Royer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna L. Jones		13e. STREET ADDRESS 532 Broadwater Rd. 21012	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-32-0347		17. INFORMANT Mr. Eric Scholtz - Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-18</u> , 19 <u>85</u> , to <u>5-11</u> , 19 <u>86</u> , that (I) (we) lost <u>3/4</u> above, (I) (we) (did) <u>did not</u> view the body after death.					
22b. SIGNATURE <u>Thomas Walsh</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>5-15-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>THOMAS WALSH MD</u>		22e. ADDRESS <u>780 Ritchie Hwy Severna Park Md 21146</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5-11-86		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md.			
25a. DATE REC'D. BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 RECEIVED  
 MAY 19 1986  
 ANATOMY BOARD OF MARYLAND  
 BALTIMORE, MARYLAND  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as "not at work" or "not at home", it is marked as "not at work" or "not at home".

00000-00

UNITED STATES DEPARTMENT OF THE INTERIOR



BUREAU OF RECLAMATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the burial-transit permit from the certificate. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 9 3 0  
REG. NO. EDT

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		CHARLES F SEIVERT, JR		MAY 10, 1986		622 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
Male		Caucasion		11-27-1914		71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Lithographer		Public. Press	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Anne Arun		Severna Pk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Charles F. Seivert, Sr.		Isabella Long		no		212-05-8085	
				17. INFORMANT		ADDRESS	
				Charles H. Seivert		297 North Drive Severna Pk, Md	
				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>myocardial infarction - arterial</i> DUE TO, OR AS A CONSEQUENCE OF, (c) <i>Cor. Artery Disease</i>			
				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I			
				<i>Coronary heart failure 2 0 8 Cor. Ar. Disease 5/11</i>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET			
				5/10		86	
22a. I certify that (I) (this hospital) attended the deceased from		22b. I certify that (I) (this hospital) attended the deceased from		22c. I certify that (I) (this hospital) attended the deceased from		22d. I certify that (I) (this hospital) attended the deceased from	
above (I) (we) (did/did not) saw the body after death		above (I) (we) (did/did not) saw the body after death		above (I) (we) (did/did not) saw the body after death		above (I) (we) (did/did not) saw the body after death	
22e. SIGNATURE		22f. SIGNATURE		22g. SIGNATURE		22h. SIGNATURE	
22i. PHYSICIAN'S NAME (TYPE OR PRINT)		22j. ADDRESS		22k. ADDRESS		22l. ADDRESS	
ANASTACIO E. SUBONG, M.D.		4730 MOUNTAIN ROAD		PASADENA, MARYLAND 21122			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		5-13-1986		Meadowridge Cem.		Dorsey, Howard, Maryland	
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. ADDRESS		24d. ADDRESS	
Barranco F.H.		501 Ritchie Hwy. Severna Pk		MAY 19 1986		5/19/86	

100-81231

11-23-1014

21

11-23-1014

Occasion

also

XX

U.S.A.

England

Alphonse Public Press

2970 North Drive Elia

Anna Arun Boveris

England

Home

Isabelle

Charles F. Seiver, Jr.

297 North Drive

Seivers Avenue Elia

212-04-8085

----

no



England

2-12-1938

Burial

Baroness F.M. 201 Ritchie Way, Seivers Elia

Elia



00-08409

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6										REG. NO. 1 2 9 3 1	
1. DECEASED NAME (TYPE OR PRINT) <b>Ruth V. Sell</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5 29 19 84</b>	
3. SEX <b>F</b>	4. RACE <b>Can</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 13 33</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>52 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>5 29 19 84</b>		2d. HOUR <b>2131</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA</b>					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Jewelery</b>			
13a. STATE <b>md</b>		13b. CITY OR TOWN <b>AA</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>924 Deep Creek Ave</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence Washington</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Naomi Beck</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-28-4736</b>		17. INFORMANT <b>Lester Sell</b>		ADDRESS <b>Arnold Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>A.S.C.V.D.</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>William P. Jones</b>				TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>5/30/84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>				ADDRESS <b>695 America Crt. Davidsonville, Md. 21035</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-1-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA Co. Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hardesty Funeral Home Annapolis Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 4 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>			



00-07020

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Parts 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6  
REG. NO.

1 2 9 3 2

1. DECEASED NAME (TYPE OR PRINT) Mary Christine Sigrist			2a. DATE OF DEATH MONTH DAY YEAR May 18 1986		2b. HOUR M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 11, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7 Fernglen Ave, Glen Burnie, Md 21061				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Realtor		12b. KIND OF BUSINESS OR INDUSTRY HRC Real Est. Co.			
13a. STATE Maryland						13b. COUNTY A A Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William B. Glenn						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary S. Brockwell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Daughter) ADDRESS Mrs. Gloria L. Adams Glen Burnie, Md.		17. ADDRESS 1511 Tieman Dr. Glen Burnie, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (d) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>10 month</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10-20</u> 19 <u>85</u> to <u>5-18</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>3-10</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Long S. Hsu</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-19-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Long S. Hsu				22e. ADDRESS 7845 Oakwood Road #205 Glen Burnie, Maryland 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 22, 1986		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Md.					
24. FUNERAL DIRECTOR NAME Singleton Funeral Home				ADDRESS Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR MAY 20 1986		25b. REGISTRAR'S SIGNATURE			

BP

2500000

RECEIVED



2000000



00-07031

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the funeral home. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) ALBERT ZIEGLER SIMMS					2a. DATE OF DEATH MONTH DAY YEAR May 19, 1986			2b. HOUR 12:45AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) welder(ret)		12b. KIND OF BUSINESS OR INDUSTRY Pitt. Steel	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Millersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 66 Rol-Park Traylor Village 21108	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Simms					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Zeiss				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 216/12/0483		17. INFORMANT ADDRESS Catherine Simms (wife) same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYO CARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> , 19 <u>84</u> , to <u>5/19</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Jeffrey M. Pargament</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/19/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jeffrey M. Pargament					22e. ADDRESS 9518-B Philadelphia Rd. Baltimore, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 22 May 1986		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn AA MD			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Md.					25a. DATE REC'D. BY REGISTRAR MAY 20 1986		25b. REGISTRAR'S SIGNATURE <u>James H. ...</u>		

MEDICAL CERTIFICATION

1865

1865



20/2

00-06772

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 9 3 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MILTON ALVIN SIMMS			2a. DATE OF DEATH MONTH DAY YEAR 5 14 86		2b. HOUR 2 P.M.
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 4 23 1911	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL City, MD.		
10. CITY OR TOWN OF DEATH EDGEWATER	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PLEASANT LIVING CON. CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5 Lee Street 21401
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS SIMMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OZELLA ESTEP			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-2267		17. INFORMANT ADDRESS MRS. TEMPERANCE SIMMS 5 Lee Street Annapolis, Md. 21401	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>URINARY TRACT INFECTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MULTIPLE SYSTEM DISEASE</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Chronic</u> <u>Recurrent</u> <u>Chronic</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>S.P. Rt-Sided CVA Residual-remote; Gout.</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>5/16/86</u> 19 <u>86</u> to <u>Present</u> 19 <u>86</u> , that (I) (we) (we) saw the deceased alive on <u>5/16/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, and (we) (did) (do not) view the body after death.					
22a. SIGNATURE <u>Peter F. Verkonow MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/15/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PETER F. VERKOW MD</u>		22e. ADDRESS <u>1833 Forest Dr - Annapolis, Md 21401</u>			
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>	23b. DATE <u>5-17-1986</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PINELAWN MEM. PARK</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Annapolis A.A. Maryland</u>		
24. FUNERAL DIRECTOR NAME ADDRESS <u>WILLIAM REESE &amp; SONS MORTUARY, P.A.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 16 1986</u>			
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-00111



MAY 1 1950



00-08057

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6  
REG. NO.1 2 9 3 5  
EST

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>ANNA</b> <b>IRENE</b> <b>SLEIGHTER</b>		2a. DATE OF DEATH MONTH <b>MAY</b> DAY <b>27</b> YEAR <b>1986</b>		2b. HOUR <b>9 09 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>8</b> YEAR <b>16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Oniter</b> MIDDLE <b>Mysko</b> LAST <b>Mysko</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Victoria</b> MIDDLE <b>Mekata</b> LAST <b>Mekata</b>		16. STREET ADDRESS / ZIP CODE <b>2692 Dulaney Street, 21223</b>			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		17b. SOCIAL SECURITY NO. <b>218-12-8672</b>		17. INFORMANT ADDRESS <b>Robert T. Sleighter, 604 Edwards Rd., 21401</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Subphrenic abscess</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bowel Obstruction</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>unknown</b> <b>1 wk.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>5 09</b> A.M. MONTH <b>5</b> DAY <b>27</b> YEAR <b>1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>1/28</b> CITY OR TOWN <b>86</b> COUNTY <b>5/27</b> STATE <b>86</b>			
22a. I certify that (I) (the hospital) attended the deceased from <b>1/28</b> 19 <b>86</b> to <b>5/27</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/26</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.							
22b. SIGNATURE <b>Margaret M. Mullins, MD</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>5/28/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARGARET MULLINS, M.D.</b>				22e. ADDRESS <b>1020 CAPE ST. CLAIRE RD.</b> <b>ANNAPOLIS, MARYLAND 21401</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/30/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Woodlawn</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.,</b>				ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 29 1986</b>	
				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. It should be detached for use as the burial-transit permit. There please remove the portion of the certificate which is to be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

13088-0



APR 19 1964

APR 19 1964

0-07995

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use in the funeral home permit. Then please return certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VBA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR		8 6		1 2 9 3 6		REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EMILY B. SONGER</b>					2a DATE OF DEATH MONTH DAY YEAR <b>MAY 25, 1986</b>			2b HOUR <b>3:12P M</b>		
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>DECEMBER 16, 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
10 CITY OR TOWN OF DEATH <b>LINTHICUM</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>567 SHIPLEY ROAD LINTHICUM</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE WIFE</b>		12b KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MARYLAND</b>					13b CITY OR TOWN <b>BALTIMORE</b>		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS / ZIP CODE <b>304 WESTOWNE ROAD BALTO. 21229</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WALTER MACON</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCY REGAN</b>					
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>217-07-6379</b>		17 INFORMANT ADDRESS <b>ELISIE S. DiFATTA 567 SHIPLEY RD. LINTHICUM 21090</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UNDIFFERENTIATED SQUAMOUS CELL CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC TO LUNG, LEFT ADIPOSCITOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>SPACE - PRIMARY UNDETERMINED</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>GASTRITIS, HYPERCALCAEMIA RELATED TO CANCER</b>										
9a DATE OF OPERATION		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <b>5/17</b> 19 <b>86</b> , to <b>DEATH</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/17</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Albin O. Kuhn MD</b>				DEGREE <b>MD</b>				22c DATE SIGNED <b>5/27/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBIN O. KUHN MD</b>				22e ADDRESS <b>1001 PINE HEIGHTS AVENUE BALTO. MD.</b>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>5/28/86</b>		23c NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL PK.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MARYLAND</b>				
24 FUNERAL DIRECTOR'S NAME <b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES</b>						25a DATE REC'D BY REGISTRAR <b>MAY 29 1986</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>		
1630 EDMONDSON AVENUE BALTO. MD. 21228										

MEDICAL CERTIFICATION

1954

1954

1954

1954



00-05956

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6											
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Barbara Mae Spangle</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>5/4/86</b>			2b. HOUR <b>1028</b>		
3. SEX <b>F</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>1</b> YEAR <b>33</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>52</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA</b>	
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arunde</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	
13a. STATE <b>Md</b>				13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>21061 Md. 415 Maple Ln.</b>	
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Edward</b> LAST <b>Cayer</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mazie</b> MIDDLE <b>Matilda</b> LAST <b>McQuay</b>				16. SOCIAL SECURITY NO. <b>218 28 2108</b>			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				18. SOCIAL SECURITY NO. <b>218 28 2108</b>				19. ADDRESS <b>Glen Burnie, Maryland 21061 Ct Davis L. Spangle Jr. 8218 Crab Apple</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF <b>A.S.C.U.D.</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF <b></b> (c) <b></b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b></b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>William P. Jones</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>5/3/86</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>				ADDRESS <b>695 AmericaCrt., Davidsonville, Md. 21035</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>5/7/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>				23d. LOCATION CITY OR TOWN <b>Glen Burnie, Md.</b> STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Raymond C. Fink</b> ADDRESS <b>Glen Burnie, Md. 21061</b>											

MAY 8

REGISTRAR'S SIGNATURE



COPIES OF  
ALL  
LETTERS  
AND  
NOTES  
TO  
THE  
COMMISSIONER  
OF  
THE  
LAND  
OFFICE  
FROM  
THE  
LAND  
OFFICE  
TO  
THE  
COMMISSIONER  
OF  
THE  
LAND  
OFFICE

Wm. H. H. H.

W. H. H.

Department of the Interior, Bureau of Land Management

00-08435

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

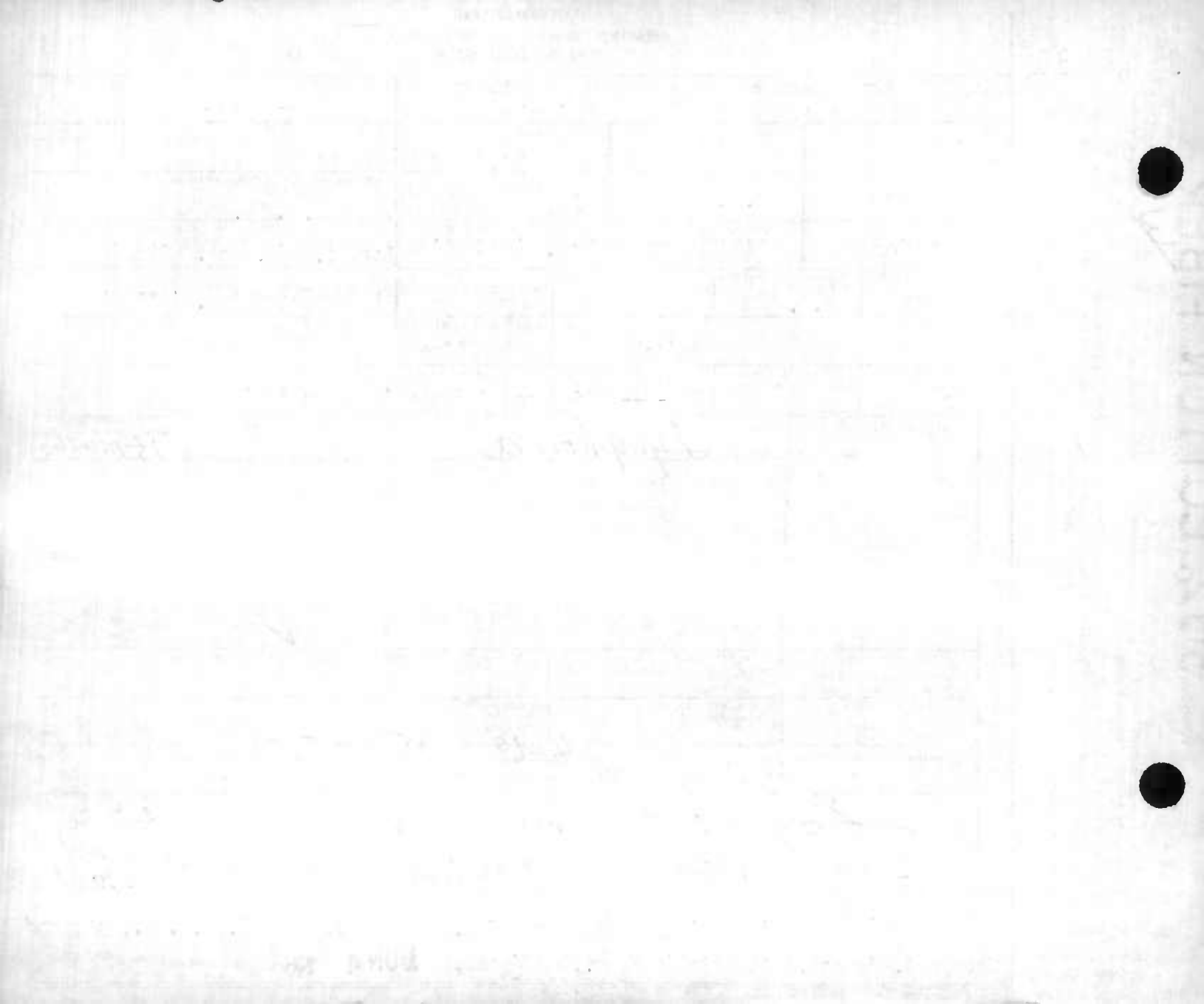
DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified *immediately*.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 2 9 3 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>aka</b> FIRST <b>George</b> MIDDLE <b>Georg</b> LAST <b>Spitzky</b>						2a. DATE OF DEATH MONTH <b>May</b> DAY <b>31</b> YEAR <b>1986</b>		2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>April</b> DAY <b>10</b> YEAR <b>1937</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A.Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Pasadena</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN IN-SITU FACILITY, GIVE STREET ADDRESS) <b>12 Margaret Ave. (21122)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>1st. Cl. Main. Mech.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Chemical</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>A.A.</b>		13c. CITY OR TOWN <b>Pasadena</b>	
14. FATHER'S NAME FIRST <b>Bruno</b> MIDDLE <b></b> LAST <b>Spitzky</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Olga</b> MIDDLE <b>Preuschoff</b> LAST <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-50-3926</b>		17. INFORMANT ADDRESS <b>Joan Spitzky (same as 13c)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-10</b> 19 <b>85</b> to <b>5-31</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5-10</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Long S. Hsu</b> M.D.						DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-2-86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Long S. Hsu</b>						22e. ADDRESS <b>7845 Oakwood Road, Glen Burnie Md 21061</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/3/ 86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn Pk., A.A.Co., Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b> , 4001 Ritchie Hgwy., Baltimore, MD. 21225						25a. DATE REC'D. BY REGISTRAR <b>JUN 4 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Juha Davidson</b>			





00-06927

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6  
REG. NO.1 2 9 3 9  
EDT 9

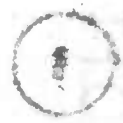
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	P.
DIANNA				SPRIGGS	MAY 16, 1986				2:40	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE	7. IF UNDER 1 YEAR		8. IF UNDER 74 HRS.			
Female	Black	4/18/1946		41	MONTHS		DAYS		HOURS	
9. BIRTHPLACE	10. CITIZEN OF WHAT COUNTRY?	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY				
Maryland	USA	NORTH ARUNDEL HOSPITAL		Housekeeper						
13a. CITY OR TOWN OF DEATH	13b. COUNTY	13c. STREET ADDRESS		13d. ZIP CODE						
GLEN BURNIE	AA	1679 Circle Rd		21144						
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT		18. ADDRESS				
Arthur	Mary	No		Jean Jones		8165 Village Rd				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
		HOUR A.M. MONTH DAY YEAR								
		P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-7</u> , 19 <u>86</u> , to <u>5-16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5-16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		22c. DATE SIGNED						
<u>Long S. Hsu</u>		M.D.		5/16/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
LONG S. HSU, M.D.		7845 OAKWOOD ROAD, #205 GLEN BURNIE, MARYLAND 21061								
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial		3/21/86		ST Rest		Glen Burnie AA Md				
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
J. B. Oden - 1631 W. 11th Ave		MAY 19 1986		<u>W. B. Oden</u>						

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*



00-07386

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 9 4 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MAGGIE May STALLINGS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5 21 86</b>			2b. HOUR <b>10<sup>10</sup> A.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 15 1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>100 YRS.</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.				
12. CITY OR TOWN OF DEATH <b>Annapolis</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>AA</b> 13c. CITY OR TOWN <b>Edgewater</b>			17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS / ZIP CODE <b>36 South River Road 21037</b>					
19. FATHER'S NAME FIRST MIDDLE LAST <b>William Cadle</b>			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Zora Bailey</b>			21. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>No</b>			22. SOCIAL SECURITY NO. <b>216-366-214</b>	
23. INFORMANT <b>Harvey Stallings</b>			24. ADDRESS <b>same as #13</b>			25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4M</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cervical Cancer**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:28 P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED <input checked="" type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Home 5/17</b> , 19 <b>86</b> , to <b>5/22</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/22</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Jack Fenderson</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/22/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jack Fenderson</b>		22e. ADDRESS <b>139 Old Solomon 152 21407</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 23, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Edwards Chapel</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel Annapolis, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 22 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Jana Davidson</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

5100

69511      50740 off

10/17 19/18 19/19 19/20 19/21 19/22 19/23 19/24 19/25 19/26 19/27 19/28 19/29 19/30 19/31 19/32 19/33 19/34 19/35 19/36 19/37 19/38 19/39 19/40 19/41 19/42 19/43 19/44 19/45 19/46 19/47 19/48 19/49 19/50 19/51 19/52 19/53 19/54 19/55 19/56 19/57 19/58 19/59 19/60 19/61 19/62 19/63 19/64 19/65 19/66 19/67 19/68 19/69 19/70 19/71 19/72 19/73 19/74 19/75 19/76 19/77 19/78 19/79 19/80 19/81 19/82 19/83 19/84 19/85 19/86 19/87 19/88 19/89 19/90 19/91 19/92 19/93 19/94 19/95 19/96 19/97 19/98 19/99 19/100



00-07196

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO. 12941

1. DECEASED NAME (TYPE OR PRINT) <b>Charles STANSBURY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5 15 86</b>			2b. HOUR <b>2200</b> M			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 10 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	

13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1802 <del>St. Margaret's</del> 21401</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES STANSBURY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MATILDA STANSBURY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-16-6072</b>		17. INFORMANT Annapolis, Md. 21401 <b>GRAFTON JOHNSON 2222 Mullberry Hill Rd.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMO COCCAL PNEUMONIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c) _____	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Renal FAILURE</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/12</b> , 19 <b>86</b> , to <b>5/15</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/14</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Alex Herteman</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>5/20/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alex HERTEMAN</b>				22e. ADDRESS <b>20 RIDGELY AVE Suite 111 ANNAPOLIS, MD 21401</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5-20-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ASBURY BROADNECK CEME.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Margarets A.A. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson Handell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please attach carbonpapers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

21-10-71

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

00-07919

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86  
REG. NO.

1294ED2

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) <b>GODLY WILLIAM STOKES</b>		MONTH DAY YEAR <b>MAY 22, 1986</b>		448 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
Male	Black	OCT 25, 1912	73 YRS	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
S.C.	USA		ANNE ARUNDEL COUNTY MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Crane operator		Govt
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MD	Anne Arundel	Gambrills	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2482 Lee St. Gambrills md 21054	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Ellison Stokes		Luck Jenkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		11/4311/45579037551		Alphenia M. Stokes 2482 Lee St, Md 21054	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Ischemia</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACUTE Anterior Myocardial Infarction</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/22/86</u> 19 <u>86</u> to <u>5/22/86</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/22/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Paul J. Young</u>				<u>5/24/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
PAUL J. YOUNG - HYMAN, M.D.		325 HOSPITAL DRIVE, SUITE 105 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		5/28/86	Harmony		Landover PG Maryland
24. FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
M. M. Dudley & Sons Funeral Home 3200 Rhode Island Ave Mt. Rainier, MD		MAY 28 1986		<u>June Dawson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

[illegible]



00-05844

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 9 4 3  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Henry</b>		2a. DATE OF DEATH <b>5/2/86</b>		2b. HOUR <b>11A</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>3/21/21</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>ANNE ARUNDEL GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION <b>STEAMFITTER SELF EMPLOYED</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND ANNE ARUNDEL COUNTY</b>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS AND CODE <b>928 DECESARIS BLVD 20711</b>
14. FATHER'S NAME <b>WILLARD</b>		15. MOTHER'S MAIDEN NAME <b>ZETTIE</b>		16. ADDRESS <b>P.O. BOX 3132</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>245-18-1831</b>		17. INFORMANT <b>WILLIAM H. STOTT ANNAPOLIS, MD. 21403</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Rectal Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
---	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>4/27</b> 19 <b>86</b> to <b>5/2</b> 19 <b>86</b> , that (1) (we) last saw the deceased alive on <b>5/2</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.			
22b. SIGNATURE <b>Enser W. Cole III</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>5/2/86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ENSER W. COLE III</b>		22e. ADDRESS <b>51 FRANKLIN ST ANNAPOLIS MD 21401</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>5-5-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NATIONAL</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND PRINCE GEORGE MD</b>
---	-------------------------	---	---

24. FUNERAL DIRECTOR <b>ROBERT E. EVANS ANNAPOLIS, MARYLAND</b>	25a. DATE REC'D. BY REGISTRAR <b>MAY 06 1986</b>	25b. REGISTRAR'S SIGNATURE <b>J. A. Davidson</b>
--	--	--

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

11-02-01



WINTER 1901

00-05764

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 2 9 4 4

1. DECEASED NAME (1st or PRINT) FIRST MIDDLE LAST <i>Nina (NMN) Stolz</i>			2a. DATE OF DEATH MONTH DAY YEAR May 2, 1986		2b. HOUR 1 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.	
10. CITY OR TOWN OF DEATH <i>Edgewater</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Pleasant Living Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY A A Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST David Throneberry			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Jones		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 416.01.1075		17. INFORMANT (Daughter) ADDRESS Marjorie Middlekauff Same as 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Pulmonary disease*

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Ben R. Jones MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 6, 1986	23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Huntsville Ala.
24. FUNERAL DIRECTOR NAME <i>B. A. Hopkins</i> ADDRESS Singleton Funeral Home Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 6 1986 <i>John W. Anderson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1077-0



2

0-07897

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 2 9 4 5

EDT

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>FRANK LEONARD STROUPE</b>			2a. DATE OF DEATH MONTH <b>MAY</b> DAY <b>24</b> , YEAR <b>1986</b>		2b. HOUR <b>1207 PM</b>
3 SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>June</b> DAY <b>11</b> , YEAR <b>1916</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD</b>		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Water Dept.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State of Md.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. CITY OR TOWN <b>A.A.Co. Glen Burnie</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>-----</b> LAST <b>Stroupe</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>232-18-9324</b>		17. INFORMANT ADDRESS <b>Mrs. Mary H. Stroupe, Same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Acute respiratory failure Severe Ch. chest lung disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b> DEGREE <b>MD</b>				22c. DATE SIGNED <b>9/5/24</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BASANT K. KHADELWAL, M.D.</b>				22e. ADDRESS <b>7422 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/27/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>	
23d. LOCATION CITY OR TOWN <b>Elkridge</b> COUNTY <b>Howard</b> STATE <b>Co. Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>MAY 28 1986</b>			
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Home</b> ADDRESS <b>237 E. Patapsco Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 28 1986</b>	

25b. REGISTRAR'S SIGNATURE  
**[Signature]**



00-07387

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return the completed pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 9 4 6  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		FIRST MIDDLE LAST Patrick J. Swift		5 16 86		10 <sup>15</sup> P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		3 15 1919		67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Philadelphia, Pa.		USA				Anne Arundel MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		138 Island View Dr.		Brick layer		Construction	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md		A.A.		Cape St John		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES)	
Patrick Swift		Zita Coons		Yes		17. INFORMANT ADDRESS #13	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES)		17c. INFORMANT ADDRESS		17d. DATE OF OPERATION	
Yes		WWII		Marie A. Swift.		17e. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		578-12-3991				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
						21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
						21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
						21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
						22a. I certify that (I) (this hospital) attended the deceased from 4/17/86, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on 5/8/86, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
						22b. SIGNATURE S. Wolgast	
						22c. DATE SIGNED 5/19/86	
						22d. PHYSICIAN'S NAME (TYPE OR PRINT) Enzor Cole	
						22e. ADDRESS Franklin St. Annapolis, Md	
						23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
						23b. DATE 5-20-1986	
						23c. NAME OF CEMETERY OR CREMATORY Lakemont	
						23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville AA Md.	
						24. FUNERAL DIRECTOR Name Address Funeral Chapel Annapolis, Md	
						25a. DATE REC'D. BY REGISTRAR MAY 22 1986	
						25b. REGISTRAR'S SIGNATURE Julia Davidson-Hendall	

MEDICAL CERTIFICATION



47

8

*[Faint, illegible text and markings are visible throughout the page, including a large circular stamp in the bottom left corner.]*



00-08519

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12947

1. DECEASED NAME (TYPE OR PRINT) Mary Jane Tayman			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-24 1986			2b. HOUR M 10:05 a.m.		
3. SEX Female	4. RACE Caucas.	5. DATE OF BIRTH MONTH DAY YEAR 8-21-1938	6. AGE (IN YEARS) LAST BIRTHDAY 46 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-24 1986		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.		
10. CITY OR TOWN OF DEATH Edgewater		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South River High School				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Bus Company
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Arnold		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Head				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 230-46-1479		17. INFORMANT ADDRESS Ronald Dale Tayman (Same as above)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Blunt Trauma to Chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:10XX 5-24 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by bus			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) school		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Central Ave. & Mayo Rd., Edgewater, Anne Arundel Co., Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER DATE SIGNED 5-25-86		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 5-27-1986		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Westview, Balt. Md.	
24. FUNERAL DIRECTOR Barranco Funeral Home			501 Ritchie Hwy Severna Pk MD		25a. DATE REC'D. BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Rodriguez</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

Female Census, 8-21-1938 45

Florida U.S.A.

Driver

x 1009 Shore Acres Rd. 21012

Laryland Anne Arnold

Leas Head

Unknown

230-46-1479 Ronald Dale Wyman (same as above)

no -----

Creation 5-27-1986 Estival Craterory estival, Calif. 44.

arrance Rumerl home 501 Ritchie Hwy  
Coversed in 21100

00-07950

Item 16b, Film G616 6/13/86 jab  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8612948

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Robert Thompson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-25-86</b>		2b. HOUR M <b>M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11-8-12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co.</b> MD.		
10. CITY OR TOWN OF DEATH <b>Anna</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Real Estate</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>Anne Arun.</b>	13c. CITY OR TOWN <b>Davidsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William R. Thompson Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy E. Lubermann</b>		13e. STREET ADDRESS / ZIP CODE <b>3819 Birdsville Rd. 21035</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-26-0569</b>		17. INFORMANT ADDRESS <b>3819 Birdsville Davidsonville Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ABCD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Obesity</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/15</b> to <b>5/25</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/25</b> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (all) (share) view the body of the deceased.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>5/27/86</b>	
22d. PHYSICIAN'S NAME (Type Current)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-28-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D. C.</b>		23e. FUNERAL DIRECTOR NAME ADDRESS <b>Hardesty Funeral Home 12 Ridgely Ave. Anna. Md.</b>			
23f. DATE REC'D. BY REGISTRAR		23g. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

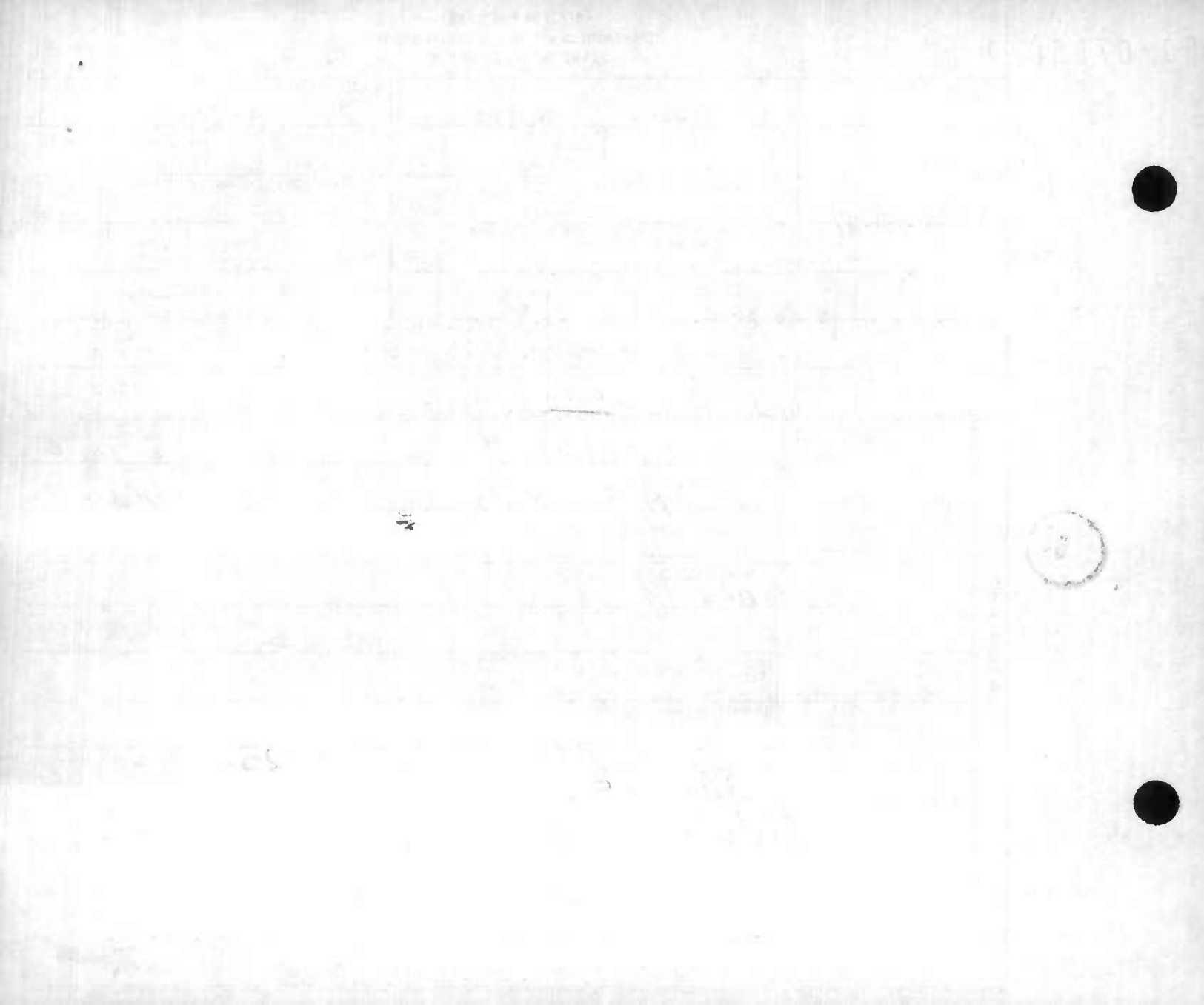
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified by the funeral director, page 3 should be detached for use as the burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-09248

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 6 1 2 9 4 9 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORIS V. TROUT				2a. DATE OF DEATH MONTH DAY YEAR 5 27 86				2b. HOUR 12 45 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 25 16		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Gen. Hosp.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. STATE Maryland				13b. COUNTY A. A. Co.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Leon L. STACK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Wilhelmina Joann a. Tuttle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 341763		17. INFORMANT ADDRESS Delores Rossiter Glen Burnie, MD 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/21, 19 86, to 5/27, 19 86, that (I) (we) lost saw the deceased alive on 5/27, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eugene W. Coley MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/27/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLEY MD				22e. ADDRESS 51 FRANKLIN ST. ANNAPOLIS MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-31-86		23c. NAME OF CEMETERY OR CREMATORY MEADOWBROOK CEM		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEY HOWARD MD			
24. FUNERAL DIRECTOR NAME BARRANCO				25a. DATE REC'D. BY REGISTRAR 2 11 46 JUN 05 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

Handwritten notes and stamps, including a large 'X' and some illegible text.

70

Anna Arnold Gen. Hosp.

1.5.1.

Nextland

Inspector Retail

Anna Arnold Gen. Hosp.

Arrested

200 Bellierov Rd. 21041

Arrested A. A. Co. Arrested

Ida

been

no

Will be in the  
delivered to the  
the 1st of 1914

Handwritten notes and stamps, including a large 'X' and some illegible text.

00-06571

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 9 5 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY Mary TURNBURKE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 9, 1986</b>		2b. HOUR <b>1727</b> Hrs M
3. SEX <b>Female</b>	4. RACE <b>CAUC.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUN 30, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>ANNE ARUNDEL</b> 13c. CITY OR TOWN <b>EDGEWATER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>11724 Ridgely Road 21037</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Selby</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Jane Doyle</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO <b>519-03-6181</b>		17. INFORMANT ADDRESS <b>same as #13</b>
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PSEUDO BULBAR PALSY, PROGRESSIVE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 YEARS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NONE</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 14, 1984</b> to <b>MAY 9, 1986</b> , that (I) (we) last saw the deceased alive on <b>FEBRUARY 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Charles W. Kinzer</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>MAY 9, 1986</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES W KINZER MD</b>		22e. ADDRESS <b>ANNAPOLIS, MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>May 12, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>P.G.</b> STATE <b>MD</b>		24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel-Annapolis MD</b> ADDRESS		
25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1986</b>		25b. REGISTRAR'S SIGNATURE <b>James Davidson-Randall</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from this file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

Handwritten notes and diagrams, including a large circle with a cross inside, and various scribbles and lines.



Handwritten notes and diagrams, including a large circle with a cross inside, and various scribbles and lines.



00-06852

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 9 5 1  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
MARY Lillian TWIFORD		5-7-86		4:50 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	CAUCASION	MONTH DAY YEAR	74	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Missouri	U.S.A.		ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Annapolis	ANNE ARUNDEL Gen.		Director		Real Estate
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE		
Maryland	A.A. Crownsville		947 Waterview Dr. 21032		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
HARRY BUTLER	Lillian				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
NO	171223690	Barbara DANIELS (same as above #13c)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>respiratory failure</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute pneumonia</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD, ASCVD</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 5</u> , 19 <u>86</u> , to <u>May 6</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>May 5</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Barbara Furlow</u>				<u>May 8, 86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Barbara T. Furlow, M.D.		77 West St., Annapolis, MD 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial	5-10-1986	LAKEMONT, Corn		DAVIDSONVILLE, AA, MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS					
Barranco F.H. Severna Park, MD 21144		MAY 15 1986		<u>J. A. Trivette</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-0000

Ward Lillian Lifford

Private Collection 11-21-11

24

Missouri (L.A. & N. Hine Lifford)

Missouri (L.A. & N. Hine Lifford)

Missouri (L.A. & N. Hine Lifford)

Missouri (L.A. & N. Hine Lifford)

Missouri (L.A. & N. Hine Lifford)



Private Collection 11-21-11  
Ward Lillian Lifford  
Missouri (L.A. & N. Hine Lifford)

00-06878

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. KRE. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP \_\_\_\_\_  
 DHMH - 17  
 (VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 9 5 2

 FOR  
 1- STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR M	
Jeffrey		Lynn		Twigg				5/ 3/ 19 86				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR		2e. MIN
MALE	KAKASION	7 - 21 - 47		38 YRS.					5/ 5/ 1986		2:45		P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		USA				Anne Arundel County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Arnold		1124 Old Stone Lane		AUDITOR		BOARD, EDUCATION							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		ANNE ARUNDEL		ARNOLD		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1124 OLD STONE CT/21012					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
EDWARD		P		TWIGG, SR.		MARY		UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		218-48-9464		EDWARD TWIGG, JR		Springfield, WVA 26763							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5/ 3/ 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
								inhaled exhaust fumes from auto in garage					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) closed garage				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1124 Old Stone Lane, Arnold, Anne Arundel, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 5/6/86	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Gregory R. Kauffman, M.D.				111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL				5-8-86		HILLCREST CEMETERY				CUMBERLAND ALLEGANY MD			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
ROBERT BARRANCO JR				495 Rtnhre Hwy. sev. pk MD 21146				MAY 15 1986				Jufanburden-Randall	

1962-11-14 - 5 pages

1962-11-14 - 5 pages

1962-11-14

1962-11-14 - 5 pages

1962-11-14 - 5 pages

1962-11-14 - 5 pages

1962-11-14

1962-11-14 - 5 pages

1962-11-14 - 5 pages

1962-11-14 - 5 pages

1962-11-14 - 5 pages

1962-11-14 - 5 pages

08118

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 2 9 5 3

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>George Luther Walking</b>			2a. DATE OF DEATH MONTH <b>5</b> DAY <b>31</b> YEAR <b>86</b>			2b. HOUR <b>5:30 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Feb</b> DAY <b>2</b> YEAR <b>1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>Edgewater</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pleasant Living Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lithographer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Magazine</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>13a. ST. MD</b>					13b. CITY OR TOWN <b>P.A.A.</b>				
13c. CITY OR TOWN <b>Annapolis</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS, ZIP CODE <b>29 W. Washington St. 21401</b>									
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>H.</b> LAST <b>Walking</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Anne</b> MIDDLE <b>J.</b> LAST <b>Hoetzschner</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>212-09-0716</b>			17. INFORMANT ADDRESS <b>Charles R. Walking 215 Chesapeake Rd. Annapolis 21401</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>advanced metastatic abdominal carcinoma</b> 1 yr. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>summer 1985</b> , 19 <b>85</b> , to <b>5/31</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/15</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (don't) (did not) view the body after death.									
22b. SIGNATURE <b>Paul Beree MD</b>			DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>6/1/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul Beree MD</b>			22e. ADDRESS <b>Box 3491 Crofton, MD 21114</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>6-1-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.B. MD</b>		
24. FUNERAL DIRECTOR (NAME) <b>Taylor Funeral Chapel</b>			ADDRESS <b>Annapolis, Md</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 2 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon paper 1, Page 4 and 2 should be filed with 112 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 states any injury, or other traumatic event, the Medical examiner must be notified of this.

BP \_\_\_\_\_

0

George Jackson, aka  
1000 1st St. N.E.  
Albany, N.Y. 12208  
was arrested on 11/11/71 at the  
FBI New York office. He was  
arrested on a charge of  
conspiracy to defraud the  
FBI of its funds.



George Jackson, aka  
1000 1st St. N.E.  
Albany, N.Y. 12208  
was arrested on 11/11/71 at the  
FBI New York office. He was  
arrested on a charge of  
conspiracy to defraud the  
FBI of its funds.



00-06575

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show the date, time, place, injury, or other traumatic event, the medical examiner shall be furnished at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDGAR SANDERS WARFIELD</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 13, 1986</b>		2b. HOUR <b>300 AM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 1, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87 YRS</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Penn. Rail Road</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A A Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE (Ferndale) <b>4 Second Ave. S. 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edgar Warfield</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella C. Watts</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT (Wife) ADDRESS <b>Mrs. Margaret G. Warfield Same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic hepatoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ascites</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5/11/86 P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>5/11/86</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>5/13/86</b>					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/11/86</u> , 19 <u>86</u> , to <u>5/13/86</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (THIS MUST BE SIGNED AND SIGNED) view the body after death.									
22b. SIGNATURE <u>Sang K. Han</u> DEGREE _____					22c. DATE SIGNED _____				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SANG K. HAN, M.D.</b>					22e. ADDRESS <b>7845 OAKWOOD ROAD, SUITE 204 GLEN BURNIE, MARYLAND 21061</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 16, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hanover A A Co. Md.</b>			
24. FUNERAL DIRECTOR NAME <u>R. H. Shokin</u> ADDRESS <u>Singleton Funeral Home Glen Burnie, Maryland</u>					25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1986</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DATE: 10/10/1964 TIME: 10:10 AM

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

RE: MURDER OF MARTIN LUTHER KING, JR.



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/1964 BY 1045

END PAGE 2



00-07099

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 9 5 5  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
Paul S. Watson		May 15, 1986		6:20 P	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male	White	MONTH DAY YEAR		81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.		Anne Arundel MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Glen Burnie		North Arundel General Hospital		Astronomer	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		Anne Arundel		PASADENA	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		211112	
Edward L. Watson		Edith Hann		339 North Ferry Rd	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		215-05-0330		Nellie Watson-spouse - AS in No. 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>bronchopneumonia</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>poorly differentiated large cell carcinoma of lung</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>October 21, 1985</u> to <u>May 15, 1986</u> , that (I) (we) lost saw the deceased alive on <u>May 15, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Jerry D. Skarbek</u>		MD		5-16-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Jerry D. SKARBEK		3708 Mountain Rd. Pasadena, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		May 15, 1986		Security Process Inc.	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
NAME ADDRESS		CITY OR TOWN COUNTY STATE		23f. REGISTRAR'S SIGNATURE	
McGully Funeral Homes		Catonsville Baltimore MD		MAY 20 1986	
3204 Mountain Rd. Pasadena, MD 21122					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



1. 18 20 21 22  
 2. 19 20 21 22  
 3. 20 21 22 23  
 4. 21 22 23 24  
 5. 22 23 24 25  
 6. 23 24 25 26  
 7. 24 25 26 27  
 8. 25 26 27 28  
 9. 26 27 28 29  
 10. 27 28 29 30  
 11. 28 29 30 31  
 12. 29 30 31 32  
 13. 30 31 32 33  
 14. 31 32 33 34  
 15. 32 33 34 35  
 16. 33 34 35 36  
 17. 34 35 36 37  
 18. 35 36 37 38  
 19. 36 37 38 39  
 20. 37 38 39 40  
 21. 38 39 40 41  
 22. 39 40 41 42  
 23. 40 41 42 43  
 24. 41 42 43 44  
 25. 42 43 44 45  
 26. 43 44 45 46  
 27. 44 45 46 47  
 28. 45 46 47 48  
 29. 46 47 48 49  
 30. 47 48 49 50  
 31. 48 49 50 51  
 32. 49 50 51 52  
 33. 50 51 52 53  
 34. 51 52 53 54  
 35. 52 53 54 55  
 36. 53 54 55 56  
 37. 54 55 56 57  
 38. 55 56 57 58  
 39. 56 57 58 59  
 40. 57 58 59 60  
 41. 58 59 60 61  
 42. 59 60 61 62  
 43. 60 61 62 63  
 44. 61 62 63 64  
 45. 62 63 64 65  
 46. 63 64 65 66  
 47. 64 65 66 67  
 48. 65 66 67 68  
 49. 66 67 68 69  
 50. 67 68 69 70  
 51. 68 69 70 71  
 52. 69 70 71 72  
 53. 70 71 72 73  
 54. 71 72 73 74  
 55. 72 73 74 75  
 56. 73 74 75 76  
 57. 74 75 76 77  
 58. 75 76 77 78  
 59. 76 77 78 79  
 60. 77 78 79 80  
 61. 78 79 80 81  
 62. 79 80 81 82  
 63. 80 81 82 83  
 64. 81 82 83 84  
 65. 82 83 84 85  
 66. 83 84 85 86  
 67. 84 85 86 87  
 68. 85 86 87 88  
 69. 86 87 88 89  
 70. 87 88 89 90  
 71. 88 89 90 91  
 72. 89 90 91 92  
 73. 90 91 92 93  
 74. 91 92 93 94  
 75. 92 93 94 95  
 76. 93 94 95 96  
 77. 94 95 96 97  
 78. 95 96 97 98  
 79. 96 97 98 99  
 80. 97 98 99 100

00-05751

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 9 5 6

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert Edward Whittington Sr.</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 <b>5 4 1986</b>			2b. HOUR <b>2350</b>		
3. SEX <b>Male</b>	4. RACE <b>Cau</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 19 39</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>47</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>5 4 1986</b>	7d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A.Co.</b>		
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Elevator Mech. Consol. Ele, Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>md</b> COUNTY <b>AA Co.</b> CITY OR TOWN <b>Millersville</b>			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS <b>21108 Millersville, Md. 8241 Brandon Dr.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sylvester ----- Whittington</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Erma ----- Brennager</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219-26-2664</b>		17. INFORMANT ADDRESS <b>Mrs. Aurelia P. Whittington, Same 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF <b>A.S.C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>William P. Jones, M.D.</b>					TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>					ADDRESS <b>695 America Crt., Davidsonville, Md. 21035</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/9/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemt.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. A.A.Co. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Balto. Md. 21230</b> <b>McCully Funeral Home,</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 6 1986</b>		25b. REGISTRAR'S SIGNATURE	



00-07983

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 also should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 2 9 5 7  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel LAVINIA Wilson		2a. DATE OF DEATH MONTH DAY YEAR 5 24 86		2b. HOUR 8:15 P.M.
3. SEX F	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 19 09		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.
7a. BIRTHPLACE (COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		10. CITY OR TOWN OF DEATH Annapolis		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (IF WORK FOR MOST OF WORKING LIFE) Retired School Teacher		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. CITY OR TOWN A.A.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HENRY JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Betters		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-38-0395		17. INFORMANT Tyrone Johnson
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of colon		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 16, 19 86, to May 24, 19 86, that (I) (we) last saw the deceased alive on May 24, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joel B. Klein		DEGREE M.D.		22c. DATE SIGNED 5/25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel B. Klein		22e. ADDRESS 2525 Riva Road Annapolis, MD 21401			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-28-86	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Md.
24. FUNERAL DIRECTOR NAME C.E. Hicks		25a. DATE OF C.D. BY REGISTRAR MAY 29 1986	
25b. REGISTRAR'S SIGNATURE			

00-05083

ADDITIONAL

NOV 19 1964



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 12958  
REG. NO.

REG. NC

1. DECEASED NAME (TYPE OR PRINT) <b>Angela</b>		3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>14</b> YEAR <b>10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b>		10. CITY OR TOWN OF DEATH <b>Crofton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1725 Tedbury Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mort. Loan Proc.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Weaver Bros.</b>											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Crofton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1725 Tedbury Street 21113</b>																											
14. FATHER'S NAME FIRST <b>Angelo</b> MIDDLE LAST <b>Constantino</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Catherine</b> MIDDLE LAST <b>Gerace</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>																16b. SOCIAL SECURITY NO. <b>229 10 3142</b>				17. INFORMANT <b>Kathy Harrison</b>				ADDRESS <b>same address as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b> DUE TO OR AS A CONSEQUENCE OF: (b) <b>Disease metastatic Bladder Carcinoma</b> DUE TO OR AS A CONSEQUENCE OF: (c) <b>End stage Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b> <b>15 yrs</b>																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK WHILE <input type="checkbox"/> AT HOME				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																											
22a. I certify that (I) (this person) attended the deceased from <b>1985</b> to <b>May 17 1986</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>May 17 1986</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE <b>Ronald E. Sroka MD</b>												DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED <b>5/17/86</b>															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RONALD SROKA</b>												22e. ADDRESS <b>#3 VILLAGE GREEN, CROFTON Md.</b>																							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>				23b. DATE <b>5-21-86</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn C</b>								23d. LOCATION <b>Norfolk, Va.</b> COUNTY STATE																			
24. FUNERAL DIRECTOR NAME <b>Ives-Pearson Funeral Home</b> ADDRESS <b>Arlington, Va. 22201</b>																																			

